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ABSTRACT

Major contents of this report are the four major presentations made at a workshop designed to give 200 nursing service chiefs a uniform approach for upgrading and expanding skills and knowledge relevant to achieving the mission of the Veterans Administration (VA) Nursing Service. "Facing the Future" focuses on the VA Nursing Service as it is today, and as it is changing and reshaping into a nursing service of the 1980s. "Impact of New Roles in Nursing" presents four major areas that impact on new roles in nursing: (1) recipients of services (client, patient, resident of a long-term care facility, individual at home or in the community), (2) health care systems in which services will be provided, (3) manpower providing services, and (4) education of those providing health care services. "Accountability for Professional Self-Actualization: Continuing Challenge for Nursing" links questions of accountability to the growth and development of the nursing profession, and "Application of Systems Concepts to Health Services Management" demonstrates how the concepts of systems theory can be adapted effectively to the process of managing health service organizations and describes a sequence of five processes which are required for the management of a system: setting general goals, defining the subsystems, describing the subsystems, monitoring system performance, and adjusting the system. (BL)

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DEPARTMENT OF MEDICINE AND SURGERY
VETERANS ADMINISTRATION

Highlights of the Workshop, Chiefs, Nursing Service

DESIGNING FUTURISTIC NURSING PROGRAMS

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION

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NOVEMBER 10-14, 1975

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BETHESDA, MARYLAND

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May 25, 1976

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VETERANS ADMINISTRATION
WORKSHOP FOR CHIEFS, NURSING SERVICE*

The Workshop for Chiefs, Nursing Service, provided the 200 participants a uniform approach for upgrading and expanding skills and knowledge relevant to achieving the mission of VA Nursing Service.

The presentations selected for this publication serve two purposes. First, the material herein is of educational value, and second, the proceedings are of historical significance.

The theme, "Designing Futuristic Nursing Programs" was the basis for program content. Since the workshop was funded through Education Service and the Executive Training Center, VA Central Office, the agenda (See Appendix A) reflected a program that met the criteria set forth for programs supported in this manner.

The entire workshop was planned and implemented through the efforts of the VACO Nursing Service Staff, the Ad Hoc Committee of Chiefs, Nursing Service, and the Executive Training Center staff whose names appear in Appendix B. Cooperation and collaboration were pivotal factors for successful accomplishment of our objectives.

Virginia B. Longest

VIRGINIA B. LONGEST
Director, Nursing Service

November 10-14, 1975, Holiday Inn, Bethesda, Maryland

THEME

"Facing the Future"

OBJECTIVES

Upon completion of the workshop, participants will be able to:

Identify the most significant change in health care that will occur from decentralization.

State the expected outcome of decentralization in relation to the mission of Professional Services.

Describe the specific impact of the Ambulatory Care Program.

Indicate the expected consequences of health legislation as it will affect the VA.

Define systems approach.

Describe the use of systems approach in Nursing Service.

Identify specific nursing input which will assist overall VA policy and planning.

Discuss trends in labor relations which will affect Nursing Service.

Differentiate the legislation which assures freedom of information to the public with that which assures privacy to the individual.

MISS VIRGINIA B. LONGEST, DIRECTOR, NURSING SERVICE
ADDRESSING CHIEF NURSE WORKSHOP PARTICIPANTS

FACING THE FUTURE*

by

Virginia B. Longest

My purpose is to focus on the VA Nursing Service as it is today, and as it is changing and reshaping into a Nursing Service of the 1980's.

Let me begin by quoting from a letter written early in 1900 by Mary E.P. Davis to Isabel Hampton Robb:

"I have always contended that if the foundation was laid securely along proper lines there was not much danger but the superstructure would be a success. We are certainly laying the foundation no matter who builds upon it – let them find it as nearly faultless as possible, not cramped and narrowed down to meet one person's ideas but with every avenue for expansion and improvement open."[1]

Now, 75 years after those words were written, the nursing profession is still building the foundation, but I believe VA Nursing Service is on the first floor level. The plans, decisions, and changes that each of us are able to accomplish affects the VA Nursing Service of the future. You individually and collectively make a difference. Are we certain the superstructure of things to come is one in which we share pride for our combined contributions? Changes made today and tomorrow affect the Nursing Service for five to twenty-five years.

I am proud of every one of you who are here today because I know of your hard work, your dedication, your commitment, and your determination in the past. Also, I know you are the key persons who will facilitate nursing growth and "open every avenue."

Let me share with you our mission as viewed by Central Office Nursing Service. Our mission is the delivery of nursing care designed to promote and maintain health, prevent illness, and coordinate activities for continuity of care to the patient/client. This nursing care is provided in all of the agency's health care settings.

The unique role of Nursing Service is two-fold. First, its uniqueness is in assisting persons who need personal aid in coping with health problems, and second, nursing is available on a continual basis to meet the individual's needs.

The nursing process includes assessment of the individual's health care needs, planning with the individual and the family to meet these needs, implementation of a nursing plan, and evaluation of the results of the nursing intervention.

The Nursing Service collaborates with other health disciplines and integrates its aim into the total health plan for restoration of the individual to maximum health potential. Inherent in the Nursing Service mission are the three essential components, nursing practice, nursing education, and nursing research.

As we carry out our mission we must make every effort to keep nursing a humanizing profession with its members sensitive and aware of individuals as human persons. At this critical time in our history we have the opportunity to be more involved than ever before in shaping the kind of health care system that meets the needs of patients/clients today and in the future. Our commitment is for a significant contribution within the framework of primary care, chronic or long-term care, and acute care.

In his book, Managing by Objectives, Raia states, "Planning and control are perhaps the most basic and pervasive of all managerial functions. Planning is an intellectual activity which involves setting goals and determining how they are to be achieved."[2]

Talk delivered at the Workshop for Chiefs, Nursing Service Veterans Administration, Bethesda, Maryland, November 14, 1975.

What are the goals you have set for your Nursing Service? In Central Office these are the Nursing Service goals for fiscal year 1976.

1. Identify trends in health care and their implications for nursing practice; develop policies and guidelines to implement innovative programs for integration into the VA health care delivery system.

2. Foster an organization that facilitates professional accountability, and promotes flexibility for development of health care delivery systems.

3. Strengthen and coordinate a system of VA-university relationships which promotes excellence in patient care practices, health care delivery, nursing research, and nursing education.

4. Promote programs for continuing education and career systems.

5. Expand and communicate programs for nursing research in coordination with other research programs.

6. Promote increased collaboration and sharing of community and regional resources within and between Medical Districts.

7. Sustain national leadership to influence the practice of nursing.

8. Identify additional strategies that maximize the effectiveness of Nursing Service.

9. Improve and expand the present information systems in coordination with overall planning for automated data processing.

The VA Nursing Service, both in numbers and in quality represents an extraordinary health resource. It is the largest group of health professionals in the VA. Tables 1, 2, and 3 provide an idea of where we stand at the present time as far as grades and numbers of nursing personnel.

As I look at these figures, one thing impresses me above all else. The ratio of professional to non-professional is about one to one. Now, who should provide the first level of nursing? Is it the LPN? If this is so, then we know of one change that is essential for improved quality of nursing care in the future. What are we doing to shift the ratio? None of us should expect too much too soon, but we must give it serious consideration, with full intent to establish a different picture by 1980.

Table 1[1]

GRADES AND NUMBERS OF VA REGISTERED NURSES

Grades		Numbers
Junior		979
Associate		3,698
Full		14,001
Intermediate		3,215
Senior		758
Chief		129
Assistant Director		47
Director		14
	Full Time	22,841
	Part Time	1,608
	Grand Total	24,449

[1] *Table 2C VA Fulltime Nurses by Grade 6-30-75*

Table 2[2]

GRADES AND NUMBERS OF VA LICENCED PRACTICAL NURSES

Grades	Numbers
GS-3	503
GS-4	1,649
GS-5	3,379
GS-6	1,090
GS-7	1
Total	6,622

[2]*Table 2D VA Fulltime LPN Number, Percent in Grade, Average Salary and Age 6-30-75*

Table 3[3]

GRADES AND NUMBERS OF VA NURSING ASSISTANTS

Grades	Numbers
GS-00	61
GS-1	50
GS-2	992
GS-3	4,545
GS-4	10,856
GS-5	7,530
GS-6	1,031
GS-7	1
Total	25,066

[3]*Table 2E VA Fulltime N.A. Number, Percent in Grade, Average Salary and Age 6-30-75*

The changes in the educational preparation of VA nurses during the past 15 years, gives us reason to expect a higher quality of care in the future. The statistics on the educational preparation of VA nurses are shown in Table 4.

Many of you were VA nurses in 1960 when we started collecting these statistics. This number of people prepared at the masters and doctoral level in VA Nursing Service was not imagined by most of us.

Now the question arises. With all of this expertise available, are we certain that these nurses are utilized fully? The changes are here to see, and I believe nursing care is improving through the years. Nurses see the VA as a good place to work. Now is the time to gather forces, and set our goals and expectations higher than ever before. The timing is right, the future is now. By tomorrow, today becomes yesterday.

What are we doing to assure a changing dimension for VA Nursing Service? I would like to share an overview of some of the activities planned in Central Office, which touches in a very personal way each Nursing Service represented here today. First, there are the conferences and task forces.

Table 4*

NUMBERS OF VA NURSES WITH BACCALAUREATE AND HIGHER DEGREES

Year	B. S.	M. S.	Ph. D	TOTAL
1960	2,658	429	–	3,087
1961	2,990	454	–	3,444
1961	3,304	504	–	3,563
1963	3,241	524	1	3,766
1964	3,304	571	5	3,880
1965	3,329	610	5	3,944
1966	3,762	611	9	4,382
1967	3,649	623	7	4,279
1968	3,645	615	5	4,265
1969	3,818	620	7	4,445
1970	3,634	646	5	4,285
1973	4,406	1,909	15	6,330
1974(June)	4,997	2,434	15	7,446
1974 (Dec.)	5,116	2,748	15	7,879
1975 (June)	5,513	2,984	15	8,512

We are planning for at least two additional conferences with the Ad Hoc Committee of Chiefs, Nursing Service before the end of the fiscal year 1976. Since you are aware of the advisory and communicative functions of this committee, you will appreciate the importance of these meetings which provide a critical link for our plans and actions.

A Task Force to Develop Standards for Geriatric Care in VA will meet in February and May of 1976.The task will be to prepare standards of nursing care for geriatric patients in VA health care facilities. There will be 8 individuals from the field representing service, education and research in geriatrics.

Another task force will be the one which will study the "Roles and Relationships of the Associate Chief, Nursing Service for Education." This group will be made of 6 ACNSE's who will be a cross-country representation of ACNSE's. They will meet on December 3-4-5, 1975, to assess the changing role and relationships, and to make recommendations regarding optimum functioning of the individual in the role.

The Task Force to Develop Guidelines for the Mental Health Nursing Program will meet three times, February, April, and June, 1976. This eight member group will be representatives of nursing service, education, and research.

In April 1976, a Task Force will study the Role, Function, and Standards for Nurse Epidemiologists. The 7 Nurse Epidemiologists participating in these tasks will represent both service and research.

RCS 10-220 June 30, 1975

And now, a review of our plans for educational programs. I hardly need to speak of the importance we place on this Workshop for Chiefs, Nursing Service. Our target endeavor is to bring about a change. The expectation is that you upgrade and expand your skills and knowledge relevant to current health trends occurring in the VA and throughout the national health scene; that you act as catalysts to increase the emphasis on quality of patient care; that you refocus the direction of nursing throuth such processes as redefining priorities; and that you forecast and identify new areas of responsibility brought about through decentralization. Together we are accomplishing the purposes of this workshop.

Another workshop will deal with Nursing Career Development. Its purpose will be to prepare Associate Chiefs, Nursing Service for Education to plan and implement a systems approach to nursing career development for all levels of nursing personnel. This will focus on the ever growing need to support the development of career-minded nursing personnel, career mobility, and opportunities that only a national health care service such as ours will offer. A systems approach to career development will open avenues for those presently in the Nursing Service. It will enhance recruitment and retention of well qualified persons, and it will establish stepping stones for our goal-directed career employees. Twenty-eight ACNSE's will attend this workshop, one from each Medical District, with the intent that upon their return they will hold mini-workshops for key persons representing the other health care facilities in their Medical Districts.

We will continue the training programs to prepare key personnel, both Chiefs, Nursing Service and Associate Chiefs, Nursing Service for Education. Nursing Service will use a total of 138 man months for this vital training during fiscal year 1976. A spin-off of this program will be the developmental experiences many of you will have as preceptors.

An additional program for training newly appointed key leaders who have not been trainees will be available. This program will be for selected, newly-appointed, key, administrative, nursing personnel who need to broaden their experiences. Some individuals newly-appointed to centralized positions need to acquire a broader orientation than can be accomplished at assignment sites. Often it will be beneficial to detail the individual to another hospital, or to Central Office, so the person will see the responsibilities inherent in the position. For example, when an Assistant Chief, Nursing Service will be assigned to the role of Chief, Nursing Service, the individual may profit from a training experience, and will be able to become more productive within a shorter time. We expect to provide these training experiences for 20 persons before July 1976.

We will be assisting with tuition costs of programs which prepare Nurse Practitioners for Adult Care. It will be essential to prepare nurses for expanded roles in order to upgrade the quality of services offered veterans. These nurses will be learning skills in primary health care decision-making; in assessing physical and psycho-social health-illness status of clients; in promoting health maintenance and protection against disease; and in managing the care of patients/clients.

We will be making every effort to have a Fourth Annual Nursing Research Conference. Persons who will attend will be nurse researchers or specific nurses who have completed nursing research studies. The conference will be held to enhance communications between researchers, and to encourage VA nurses to systematically investigate problems related to clinical care of patients.

There will be an educational program in Behavior Modification Techniques designed to include approaches to behavior analysis, assessment, reinforcement techniques, evaluation, and recording in the Problem Oriented Medical Record format. The desired goal will be to having nursing care interwoven with a multidisciplinary approach for more progressive standards of care in the mental health environment. Participants of this program will be 14 selected nurses, a cross-country representation from the mental health facilities.

There will be several other programs which are multidisciplinary in nature, in which nurses will be actively involved. Some of the programs will be as follows:

1. Developing Education Programs in Centers for Aging.

2. Educational Preparation of RN's in Spinal Cord Injury Centers.

3. Designing Educational Strategies for Long Term Nursing.

4. Problem Oriented Medical Record Workshop.

5. Workshop in Rehabilitation Skills.

6. Designing Educational Programs and Strategies for Effective Learning.

7. Responsibilities for Patient Education.

8. Quality Assurance Program.

These multidisciplinary programs will be offered mainly through Regional Medical Education Centers in Minneapolis, Saint Louis, Salt Lake City, and Birmingham.

Seventy-five persons recently attended a multidisciplinary Workshop on Health Service Review Organization in October, 1975. Nurses and other professionals were prepared to assist and teach others the fundamentals of the HSRO Program in all of the VA health care facilities. The target date for completion of the training in health care facilities was set for May 1976.

The scope of these activities will be aimed at changing the dimension of established on-going programs. In the long run it will be up to individuals. In part it will come from those who attend the task forces, conferences, and educational courses. It will be from you our Nursing Service leaders, however, that the real changes will occur. Do you plan to nurture new roles in practice? Do you plan to build the needed research into your existing structure? Our accountability must be personal, professional, and organizational.

We have facilities and resources, so let's move forward with confidence and determination. It is said that in any large organization, leaders are in one of three groups. One group is hanging on to the past. Another group jumps on every band wagon, takes on unproven methods, and quickly discards tradition. The third group tries to mesh actions of the other two. Which group is yours?

The foundation of the VA Nursing Service has the imprint from the work and dreams of many. It is my dream that as each of us here today leave our own mark, we know the superstructure is rising because we have expended our very best efforts. As we work with others in our own profession as well as with those in other disciplines, we know the world changes with or without us. We must rely on our own self-control, not on control over others but rather on control over operations. Let's see to it that the VA Nursing Service of 1976 goes down in history as the most progressive and viable ever known.

REFERENCES

1. Lewis, Edith P., Editorial, *Nursing Outlook*, Vol. 23, No. 10, October, 1975, p. 621.

2. Raia, Anthony P., *Managing by Objectives*, Scott, Foresman and Company, 1974, p. 7.

RECOGNITION CEREMONY

On Monday, November 10, 1975, Dr. John D. Chase, Chief, Medical Director presented recognition awards as follows:

- **Chief Medical Director's Commendation** to the Nursing Service, VAH, West Side, Chicago. In recognition of the outstanding performance of all employees. The award was accepted by Mrs. Bobbie Vance, Chief, Nursing Service.

Mrs. Bobbie Vance, CNS, Chicago (West Side) receiving CMD Honor Award for (WS) Nursing Service from Dr. Chase

- **Chief Medical Director's Award of Honor**, The highest honor award in the Department of Medicine and Surgery. Granted to eight Chiefs, Nursing Service, by the Chief Medical Director on a very selective basis for distinguished services to the Department. Those who received the awards were as follows:

Mrs. Agnes Black, VAH, Lexington, Kentucky
Miss Arline Burns, VAH, Cleveland, Ohio
Mrs. Anna Lee Chalfant, VAH, Prescott, Ariz.
Miss Marguerite L. Burt, VAH, San Antonio, Texas
Miss Beatrice L. Murray, VAH, Hines, Illinois
Mrs. Helen Phillips, VAH, Los Angeles, Wadsworth, California
Miss Mary E. Prichard, VAH, Memphis, Tennessee

CMD AWARDS BEING PRESENTED BY DR. CHASE

Mrs. Agnes Black, CNS, Lexington

Miss Arline Burns, CNS, Cleveland

Miss Marguerite Burt, CNS, San Antonio

CMD AWARDS BEING PRESENTED BY DR. CHASE

Mrs. Anna Lee Chalfant, CNS, Prescott

Miss Elaine deBorra, CNS, Long Beach

Miss Beatrice Murray, CNS, Hines

Miss Helen Phillips, CNS, Los Angeles (Wadsworth)

Miss Mary E. Prichard, CNS, Memphis

• **Chief Medical Director's Award of Honor** to Miss Virginia B. Longest Director, Nursing Service, In recognition of extraordinary leadership and commitment to fulfill the mission of the VA Nursing Service.

Miss Virginia B. Longest,
and Dr. Chase

• **The Director, Nursing Service, Commendations** were presented to two Chiefs, Nursing Service by Miss Virginia B. Longest, Director, Nursing Service. Those receiving the awards were as follows:

Miss Gloria Nunley, VAH, Ann Arbor, Michigan In recognition of her outstanding accomplishments during a recent period of crisis.

Mrs. Theresa Cheyovich, VA Outpatient Clinic, VAH, Los Angeles, California In recognition of her contribution through the research project entitled, "Study of the Nurse Practitioner in a Veterans Administration Outpatient Clinic."

Miss Gloria Nunley,
Miss Virginia B. Longest, and Dr. Chase

Mrs. Theresa Cheyovich,
and Miss Virginia B. Longest

IMPACT OF NEW ROLES IN NURSING

Faye G. Abdellah, R.N., Ed.D., LL.D., F.A.A.N. *

The Department of Health, Education, and Welfare has recently issued a "Forward Plan for Health for 1977-1981"[1] which identifies several health strategies and how these might be achieved. The central theme underlying all the strategies is Preventive Health Care.

This morning I would like to discuss with you four major areas that impact on new roles in nursing that need to evolve if we are to meet the health needs of Americans and develop necessary strategies to meet these needs.[2,3,4]

These areas are:

I. Recipients of Services: the client; the patient; the resident in a long-term care facility (This might be an elderly person, one who is mentally retarded, or developmentally disabled); the individual at home or in the community

II. Health Care Systems in which services will be provided;

III. Manpower Providing Services.

IV. Education of Those Providing Health Care Services.

First, what has happened to the population over the past decade? The annual death rate has remained constant at 1,000 per 100,000 population although there are variations in segments of the population, such as males versus females, whites versus non-whites.

Second, inpatient facilities have increased to approximately 7,000 hospitals and 28,000 long-term care facilities. The number of acute care beds has risen to 850,000 and 228,000 (28%) are unoccupied. More than 4 1/2 million men and women in 200 occupations are employed in the delivery of health services. Expenditures from illness and injury have risen to over $200 billion, $80 billion representing direct costs for personal health care services. Hospital costs per admission have risen from $127 in 1950 to $174 in 1972 with a predicted increase to $1,000 by the time gasoline gets to be a $1 a liter. Who pays for the health dollar? Third-party payors now cover 90% of the total expenditures for hospitalization. Public funds cover one-third of the total for persons under 65, and two-thirds of the total expenditures of those over 65. In spite of this, recipients of Medicare pay more out-of-the-pocket expenses for health services than they did before the advent of Medicare. (Title XVIII) in 1966.

There are obvious problems of distribution, provision, utilization, and unparalleled rising costs of providing health services. As some form of National Health Insurance evolves, never before in the history of American nursing does a greater challenge confront us!

As we view the impact of new roles in nursing can we in all good conscience believe that health is a *right* of every American?[5] A right is more than just an interest that an individual might have or a state of being that an individual might prefer. A right refers to entitlements–not those things which would be nice for people to have but rather those things which they are *entitled* to have. The term right is often confused with the concept of equality and this is particularly true when we speak of rights to health care and equality in respect to health care. The right to health care for every American is an idealistic goal but equality of health care in terms of access,

*Paper presented at workshop for Veterans Administration Chiefs, Nursing Service, November 12, 1975, Bethesda, Md.

provision of services, and costs may not be attainable. Therefore, as nurses we need to look at new roles in nursing and develop strategies that are based on an optimum level of health services to be provided rather than upon a maximum level. For example, more than 10 million Americans could benefit immediately from renal dialysis. Yet neither the manpower nor the resources are available to provide these needed services. Another example is that in DHEW we would like to activate a national program of home health services to provide for services for one-third of long-term care patients who do not belong in institutions such as nursing. There is now no national community network to provide the needed back-up services. A realistic fact is that 50 percent of the Visiting Nurses' Associations have only two or fewer nurses on their staffs.

If health care is a right of every American we must recognize that medical care with its emphasis upon "curing" rather than "caring" represents only a very small if not marginal contribution of health care services. It has been stated that 80 percent of illness is functional, and can be effectively treated by any talented healer who displays warmth, interest, and compassion. Another 10 percent of illness is wholly incurable and the remaining 10 percent in which scientific medicine–at considerable cost– has any value at all. Our dilemma is that our educational systems, costly institutional facilities (228,000 beds unoccupied), provided are designed predominantly to meet the requirements of the 10 percent of individuals who can benefit from scientific medicine. Recognizing the many dilemmas with which we are faced let us now turn to the four points I made initially:

I. The Recipient of Services. The client, i.e., the patient, the resident or individual recipient of health services all are a part of a delivery system of health. Such a health care delivery system must:

- provide a full range of medical and health services;
- have the capability of serving a population defined by geography and enrollment;
- provide an organization and a system of accountability;
- provide a unit record system that is a family-linked system;
- have the capability of providing a 24-hour accessible services; and
- provide transportation and linkage with an emergency health services system.

Several models for health care delivery are presented in a recent American Academy of Nursing publication.[6]

An integral part of the health care delivery system is *primary* care which is unavailable to most people today. Primary care is a continuous source of care to which an individual or family *first* must turn for help in each episode of illness. Primary care must also " . . . educate clients to preventive measures and offer them regularly, whether these are immunization of a child, antepartal care, or alcohol and drug prevention." Doris Schwartz describes six stages of primary care:[7]

1st stage: Purely preventive–the preservation of existing health both physical and mental,

2nd stage: Also preventive but addressed particularly to those individuals at special risk for a variety of reasons, e.g., genetic (sickle cell anemia), poverty, lack of motivation.

3rd stage: Early detection of existing problems both physical and mental.

4th stage: Manifest illness: the acute stage to which the present health system directs its greatest effort.

5th stage: Rehabilitation (needs to be activated from time individual identified as a patient).

6th stage: Those persons for whom care or some degree of rehabilitation is not possible. Primary care is also concerned with monitoring to alleviate unnecessary suffering and prevent crippling complications, according to Virginia Henderson, "letting the chronically ill person die as he would want to die if he had the strength and the will and the knowledge to control the circumstances for himself."

II. A health care system having the characteristics described previously will require major changes in what we now consider appropriate facilities in which health services are to be provided. Major structural reforms of traditional patterns of providing health services are needed. Most health services need to be extended into the community through Health Maintenance Organizations, neighborhood health centers, home health agencies, day care centers, etc. These services must be available seven days a week for each 24 hours. The National Comprehensive Health Planning Act of 1974 represents milestone legislation in which nurses everywhere must take an active role in shaping health care delivery systems and identifying our specific roles in providing needed health services.

III. Manpower. The roles of nurses already are undergoing many changes and as licensed practitioners will increase substantially as they become more independent in their practice and take more aggressive roles in decision making. The Billings, Montana, ruling firing physician assistants for practicing nursing without a license is a significant general counsel decision supporting the right of only *licensed* nurses to function as independent nurse practitioners and practice nursing. New types of nurses will appear in addition to those now highly specialized in acute care–the family nurse practitioner who can deal with major health problems particularly those that are preventable (e.g. smoking, alcoholism, drug addiction, genetic problems, child abuse, mental illness). Multiple health care delivery systems will require nurses to assume leadership roles in administering these systems–e.g., HMO, ambulatory clinics, planning for health services, and delivery of health services. We are moving steadily toward securing a direct reimbursement mechanism that will cover payment for nursing services provided in community settings and homes.

Research in nursing practice will be the key to identifying strategies to cope with health problems and outcome measures to assess the services provided. Some of the problems basic to nursing research that must be addressed are:[8,9]

1. Paucity of nurses prepared and functioning as nurse researchers.
2. Lack of financial support for nursing research.
3. Lack of incorporation of research findings into practice.
4. Lack of integration of researcher role into the employment situation.
5. Dearth of good clinical studies.
6. Need for instruments and criterion measures to evaluate effects of nursing care.

IV. Education of Those Providing Health Care Services. Many changes in the systems of nursing education are required if the strategies outlined previously are to be achieved and if health care services are to be related to those who need these services. Primary health care practitioners and gerontological nurse practitioners are top priorities. Both undergraduate and graduate nursing programs need to be redesigned to prepare these individuals. Preparation in leadership and decision-making skills are paramount. We no longer can afford the proliferation of

nursing schools. Educational efforts, due to limited economic resources, will have to be accountable to society and the demands of the consumer. Hospital based programs will decrease. Baccalaureate and higher degreed programs will undergo major changes in order to adapt to the demands of health care delivery systems. Clinical practice will shift drastically to community health settings and long-term care facilities. The shift of the base of employment away from acute care settings to community based settings will occur.

I would like to use the area of long-term care as an example of how we in DHEW are bringing about some changes in long-term care. There were several lessons documented by facts in our long-term care survey that cannot be ignored.[10]

Institutional care causes deterioration of individuals in as little time as six months after admission. An individual who is ambulatory can in this time become a bed patient, incontinent, disoriented (drug abuse, nutrition imbalance). We are taking steps to change the entire survey certification process to place emphasis upon assessment of the services provided using a patient assessment instrument developed by Densen, Katz, and Flagle.[11] The focus here is on outcome measures rather than on the process.

We also learned that most physicians and professional nurses have turned their backs on those individuals needing long-term care. Major changes are being directed at changing undergraduate and graduate curricula to include content areas and clinical practice in long-term care. Legislation has been passed to provide support for primary care practitioners and gerontological nurse practitioners.

The Forward Plan 1977-81 mentioned previously, focuses upon key health problems that are preventable and strategies are outlined to resolve these problems.

In summary, I have tried to highlight key areas that will impact on new roles in nursing. The actions you take at this workshop will greatly influence nursing practice in 1977-81.

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Accountability for Professional Self-Actualization: Continuing Challenge for Nursing*

by

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Introduction

As I prepared my talk on professional accountability, I was reminded of a quote from John Gardner's book *The Recovery of Confidence*, to the effect that "institutions have been caught in the savage crossfire between uncritical lovers and unloving critics! On the one side, those who loved their institutions tended to smother them in an embrace of death, loving their rigidities more than their promise and shielding them from life-giving criticism. On the side, there arose a breed of critics without love, skilled in demolition, but untutored in the arts by which human institutions are nurtured and strengthened and made to flourish. Where human institutions are concerned, love without criticism brings stagnation; and criticism without love brings destruction." (Gardner, 1970)

I have tried to prepare this talk as "loving critic" of the nursing profession, for in questions of accountability, there is nothing more useless than "uncritical lovers" or "unloving critics."

I was asked to discuss professional accountability today, with a special focus on the nursing profession. As I worked my way through the topic, at every corner I came to the question, "Accountability to whom–for what?" I will travel through what is likely familiar territory to many of you, and will highlight what are probably traditional answers to the question, "accountability to whom for what?" At the end of our journey together, however, I hope I will provide further directions for greater professional accountability.

In order to get where I am going, I need to deal with the following three topics:

(1) First, I would like to describe the nursing profession in the context of its growth and development;

(2) Second, I would like to draw some parameters around the general question of accountability and accountability in the health system; and

(3) Third, I would like to link questions of accountability with emerging developments in the nursing profession.

The Growth and Development of Nursing

Let me recall for you briefly some of the developments in nursing that have brought us to the questions of professional accountability. This will require our going back a bit into history. Philip Weiler has described this so well in the recent *American Journal of Public Health*. He notes that, "Nursing as a profession has had an identity struggle right from the very beginning. It first arose to satisfy a fundamental need in all families for care of its sick members. The dominating influence in nursing in those early stages was the religious one, which still plays an important role today. The nurse assumed the dual role of healer and mother surrogate. (Boyly, 1961) These roles were present in peaceful coexistence from the earliest times until the latter part of the 19th century, which marked the starting of the bacteriological era and the Women's Rights Movement. In progressing toward

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self-actualization, the nurse's professional role became inextricably entangled in the struggle for self-actualization of her feminine role.

"Florence Nightingale's establishment of the first school of nursing at St. Thomas' Hospital, in 1860 was a "foot in the door" event. Up until this time few people thought nurses should have or even needed any training, much less formal education. Once introduced, however, the idea of education spread rapidly. Nursing was carried along with the general feminist movement both for the education of women and toward professional status.

"Nurses began receiving more education and developing increased specialization to enhance their independent healer role. They were no longer content to blithely accept the "hand-me-down" functions of the physician but attempted to develop equal status and functional autonomy by establishing collegiate programs.

"Although Florence Nightingale did much to improve the image and competence of nurses and eliminated some of the servile and demeaning aspects of the occupation which existed prior to her time, she failed to recognize that she was providing for more education for nurses but not for any more independence of thought which the education produced. Her training emphasized motherly duties, "communion with God," and complete submission ("Let us not question so much. We are not more likely to be right than they (physicians) are"). (Nightingale 1914) She made clear that she did not want to "rock the boat" with a "new order" of nursing in relation to physicians.

"The nurse," according to Weiler, "has struggled into the decade of the 1970s burdened by the residue of what have become several conflicting positions: (1) subordination to the physician; (2) confinement to the hospital base where 63 percent are presently employed; (3) diminished role as healer because of decreasing patient contact (i.e., nurse doesn't nurse but sees that the patient is nursed) (4) emphasis on role as mother surrogate which is now in conflict with the rule of the liberated woman; and (5) increased education and independence.

"These positions are pulling nursing in opposite directions. One direction stimulated by the increased emphasis on education and by the feminist movement. This direction leads to a concept of nursing which searches for a professional identity and functional autonomy, eliminates subordination to the physician, and demands peer status in patient care. The contradiction in this concept of nursing is that to achieve these aims in hospital settings nursing is focusing on the psychosocial dimensions of patient care, neglecting the physical sciences, and becoming more managerial in function. The technical skills of nursing which are the components of the discrete tasks designed to help and comfort patients undergoing a therapeutic program are deemphasized. As a result of this the nursing profession is put in the position of no longer actually practicing nursing.

"Another direction is the together-but-subordinate direction which follows along traditional lines. This direction leads to a concept of nursing which is very task-oriented and usually hospital-based with no functional autonomy. The nurse is in a dependent role, carrying out the physician's orders, which requires a minimum of background knowledge. While this role provides the nurse with direct patient contact and emphasizes actual nursing practice, it is even more of a block to self-actualization than the other direction. With a task approach there is little opportunity for intellectual development for one who has been drilled in the importance of increased education for the nurse. Her feelings of a subordinate role to the physician perpetuates a gulf which forces the nurse to work more closely with aides and attendants than with physicians in the care of patients.

"According to the National Commission on Nursing and Nursing Education, in professional nursing's struggle for self-actualization, the nurse has been working under 'conditions of economic depression, environmental deprivation and role confusion which are endemic to much of American nursing' (National Commission, 1970 p. 26. In their struggle, nurses must overcome both the sex barrier and the class barrier of the health pyramid with the physician on top. As a result of such a struggle, over 285,000 nurses—almost one-third of all registered

nurses–have given up the struggle and are not practicing their profession and there is also a high turnover rate of nurses in many hospitals." (Weiler, 1975, 861-862) Now you are asked to be accountable as a profession in spite of these problems!

Accountability – What is it?

Accountability implies first of all answerability or responsibility for performance. The professional, because of his/her expertise, has claimed freedom from outside control. This immunity has crucial implication for the exercise of self-regulation and peer review of competency by professional members. (Rothman and Perrucei, 1971; Wilbur, 1972).

When we think about accountability, we think about *output*–the results obtained for resources expended. This means that those responsible for health care must state their objectives in measureable terms; choose effective means for accomplishing each objective; operate the program in an efficient manner; disclose how close services have come to achieving objectives together with costs of the achievement; and then to make the necessary changes in the procedures and manner of operation to close the gaps that are revealed. Accountability in this sense is not just achieving desired results, it is achieving them in the most economical way possible.

Federal legislation that gave birth to Medicare and Medicaid in 1965, and further health legislation passed in 1972, made health providers responsible for applying quality controls to their services as a way of assuring accountability for public funds. An impression one gets from reviewing the history of Medicare is the profound shift in opinion within recent years concerning what is needed to improve health care for the American people. When Medicare started in July 1965, it was felt by most professionals that the only thing necessary to improve care was to infuse money into the health care system by primarily subsidizing care for that segment of the population that found itself unable to pay for its own care. It is hard for us to understand in 1975 how Congress could have been persuaded that essentially only more money was needed. Reflecting the concerns of the Health Insurance Benefits Advisory Council a major report was issued in which 15 administrative recommendations were made–all of which reflected on the quality of care (Breslow 1974) and hence on accountability.

It is obvious, therefore, that quality of care and accountability have become linked in the health care field. It is possible to examine the issues separately, but indeed in the final analysis, when we focus on *outputs* in the form of health status of the population. We cannot separate them from the quality of *inputs*.

The Accountability System

Because we have individuals trained as professionals acting in organizations to provide care, we have not one kind of accountability but several, which comprise what is, in effect, an accountability system:

(1) Personal accountability,

(2) Professional accountability, and

(3) Organizational accountability.

The personal accountability subsystem has a humanistic connotation that one may observe in the commitment of personnel "to go the extra mile," to care for the powerless and the less favored as diligently as well as for the powerful and the highly favored. It is shown in the willingness to deal with the "tough problems." It is shown in the candor with which problems are faced, exposed, and treated.

The professional accountability subsystem is made up of the skills, attitudes and understandings that form the knowledge base of health-care services. It requires that each worker be responsible for both knowing and using those good practices which are the product of research and the state of the art; that the worker take part in the setting of those standards; that he submit to the measurement of his performance according to those standards, and that he/she strive to meet them where results show that he/she is deficient. We are perhaps most familiar with this accountability subsystem. It is here we have done the most with audits.

The organizational accountability subsystem attempts to relate in the most general and persuasive way all of the parts–human, material and organizational–that can be joined to achieve a purpose. It forces the decision-maker to consider such elements as staffing, budget, operations, providers, and policies needed to achieve optimal results. (Lessinger, 1975)

We have, therefore, in this context three different kinds of accountability to be concerned with: (1) Our accountability to ourselves as human beings, (2) our accountability to our professions, and (3) our accountability to the organizations of which we are a part.

One could say logically that accountability in this system is on the person primarily, on the person in the profession secondarily, and on the person in the profession in the organization or institution thirdly. In terms of the realities of the present health care process, however, the priorities are probably reversed–with the accountability of the institution coming at the top of the list (at least this is what the now famous Darby decision has decreed.) and personal accountability last.

Accountability versus Humanism

A dilemma we face here is that while accountability is being pursued in the health care system, at the same time we have a renewed interest in humanizing the system. Both forces seem to be pressing for fundamental changes in the way services are provided.

On one hand, accountability provides the public with evidence that the money it is spending is actually attaining the specified objectives, or if not, that the measurements of deficits are available and that changes are being instituted to correct the problems. Humanism, on the other hand, involves values and attitudes. Individually it means that health care is primarily concerned with human beings, not with diseases or disabilities which are the focus of most quality audits.

Organizationally it means that institutions serve human beings, not the other way around. In questions of accountability it means that the proper focus is not upon the input of resources into institutions, but upon their services to human beings and the subsequent health status of the population served.

Some humanists are uneasy with the concept of "accountability" because of its attention to management, planning, insistence on quality control, and measurement of results using quantifiable data. However, accountability and humanism are complementary concerns, and both are involved in providing high quality care. How can we account for humanism in accountability measures and quality audits though? Who is interested in humanistic accountability?

Humanism in health services in grounded in the insight that caring for persons–particularly those who are unlucky, unfavored or sick, is the bedrock upon which a humane society rests.

Humanism calls for the discipline of management and technology and the compassion of individual concerns. It is therefore the product of trained, competent, and committed health professionals serving in well-managed

enterprises and becomes a focus for accountability at the personal, professional, and organizational levels. (Lessinger, 1974)

Linking Accountability with Professional Development

Two key connections need to be made at this point to relate accountability and professional development. One starts from the idea that there are conditions which must exist for a profession to be called a profession. The other starts from the idea that current procedures for assessing quality present some problems directly related to the stage of development of the profession itself.

Reviewing for a moment what it takes to become a profession, there is no doubt that an occupational grouping is not a profession until it has a body of systematic theory; until its authority is recognized by a client group of some sort; until there is a broad community sanction and approval of this authority; until there is a code of ethics; and until there is a professional culture sustained by a formal professional association. There are also a number of steps that a group goes through in the achievement of professional status, such as fulltime activity at the task; establishment of university training; redefinition of core tasks so that less skilled tasks are given to subordinates; conflict between the early visionaries and the new professionals over standards and goals; conflict between new occupations and neighboring ones; and political agitation to gain legal protection. Most progressions go through these steps at one point or another. (Etzioni, 1969; Greenwood, 1957; Moore, 1970.)

From all I can gather, the nursing profession has completed practically all tasks necessary to be described by occupational sociologists as a profession–all that is, except establishing the scientific basis for practice, which is indeed a "sticky wicket."

Kerr White said, not too long ago that, "I know of no evidence to suggest that more than 10 to 20 percent of what doctors and nurses do for or to patients is based on objective evidence that the pills, potions, elixirs, manipulations, maneuvers, advice or counsel are likely to be more beneficial and useful than they are harmful or useless. We do know that from 20 to 40 percent of all identifiable therapeutic interventions seem to be related to the placebo effect, i.e., the desire on the part of the physician or nurse to please the patient; or with the Hawthorne effect, i.e., the favorable influence associated with the general interest in the patient. The other 40 to 70 percent must, for the present, be regarded as a profound mystery and should be the objective of medical care research." (White, 1969.) Haggerty reminds us too that although there is a movement towards comprehensive health care, it is not known whether or not comprehensive health care makes the patient any better. (Haggerty, 1968.)

Abdellah noted in 1961 that, "Criterion measures are needed particularly to carry out experimental research in nursing. At present we have available monumental studies showing what the nurse does, but little information describing the effect of nursing practice on the patient's progress." (Abdellah, 1961) My recent review of literature left me with the feeling that little has been done since 1961, and that satisfactory criterion measures with scientific validity of nursing care of hospitalized patients have yet to be developed. (Simonds, 1975)

Although provision of nursing care accounts for approximately one-third of hospital's total costs, and nurses in hospitals constitute the largest single group of practitioners and over one-half of total hospital personnel, the question persists, "Does the nurse's performance have consequences for the patient?" We can, through various audit measures, answer the question, "Has the nurse performed well?" but we still are a long way from knowing if performing well or performing some functions at all makes any real difference in outcomes, and much of what is accepted is accepted on faith rather than scientific evidence.

The linkage between functions and outcomes in nursing, as in most of the helping professions, is more conceptual or theoretical than real—real in the sense of having been scientifically demonstrated.

These statements are not meant to be critical so much as to remind us of the fact and to stimulate each of us in the helping professions to do the research needed to backstop professional practice. I should recall for you, that many of us are "in the soup" together. In social work no treatment modalities have emerged as scientifically valid; in psychiatric problems, aside from drug therapies, it is probably true that medicine men and Christian Science practitioners have about the same cure rates as psychiatrists; and I can assure you from the standpoint of health education, we too have a very long way to go.

Accountability Process in Nursing

It is clear that there are very few organizations whose work is not examined retrospectively for its quality, and it is clear the same holds true for most professions. The health professional does have a great need to know if the quality of his/her decisions and actions is in keeping with the ever-increasing complexity and dynamic movement in the art of medicine, nursing, and health care delivery. He/she must know this to satisfy patients, peers, administrators, insurance carriers, and himself/herself as a professional.

We can appreciate the need for this review of our work when we consider that the half-life of a professional curriculum has been estimated to be five years. That means, simply, that half of what we learned in our professional training is probably obsolete in five years. Add to that the forgetting of what was learned, and you have the making of professional obsolescence.

Quality audits have become a way to assess how well that current practice is keeping pace with new knowledge as well as current standards of practice. They also provide one of the better routes we have, I believe, to look at past work with an eye to improving future practice. It is clear that failure to do so in a demonstrable way to meet accountability has inspired alternative measures of control through threats of malpractice, relicensure, and recertification. From a practical point of view as well as from the point of view of the professional's pride in his work, patient care audits are an inescapable necessity.

Maria Phaneuf has done so much to promote quality in nursing, and indeed more broadly, quality in health care. (Phaneuf, 1973) Her work hardly needs elaboration, for it is clear that in nursing, concern for measurement of quality of care provided to patient is not new, although one would have to admit that concern for quantification of data from that assessment is of relatively recent origin in the profession. Instruments, such as the *Slater Nursing Competencies Scale* the *Quality Patient Care Scale*, and the *Nursing Audit*, as procedures for measuring different aspects of nursing care and nursing interactions, have likely been used in some of your institutions for some time. (Wandelt, 1972)

The *Nursing Audit*, perhaps the most recent of these approaches, provides a useful way to get at a systematic written appraisal of the process of nursing care through examination of the patient-care record in a retrospective manner. With the functions of nursing care established and critical components for each function identified with numerical values, it is possible to get a quantifiable rating for each function, which in turn provides a basis for comparison, for planning actions toward improvement once a reaudit is done. I appreciate that in the VA system you have your own HSRO process, but I think the PSRO with its legislative base has important implications for nurses and the nursing profession.

Most of you are familiar with PSRO legislation, and you perhaps have been assured that nurses are becoming as actively involved as possible. It is clear that the composition of PSRO's is of extreme importance to nurses, because of the PSRO's not only may be physician-dominated but physician-controlled. It would appear that nonphysician health practitioners have little significance within the scope of the PSRO law.

"Nonphysician practitioner" is the catchall term that is used to include registered nurses, dietitians, pharmacists, physical therapists, dentists, and all others. Although PSRO's accord these professionals little importance, their participation is "expected" in developing the criteria and standards, and the selection of norms to be used for review of the care provided by such practitioners.

Many nurses realize that they may be affected by PSRO's more directly than physicians. Even if the care physicians render their patients is not approved by the PSRO, they can still bill their patients. On the other hand, nurses, especially those employed in health care institutions will not have this flexibility. If the care delivered by the nurse employed in a health care institutions is not approved by the PSRO, the institution will be unable to pass on Medicare, Medicaid, and other federal health costs. It may be necessary, therefore, for organizations employing nurses to enforce PSRO standards to ensure payment. Some believe that exclusion of nurses from PSRO membership represents an attempt by physicians to constrain the growing power of nursing. (Miller, 1975) It also implies a second class status for nursing, and indicates that, as far as physicians are concerned, nursing input into the health care system is only tangential to quality and cost of care. PSRO's do not incorporate any mechanisms by which nurses can resolve conflicts with physicians if nursing standards are unacceptable. Kay Partridge recently said before the U.S. Senate Finance Committee that "The quality of care can be adequately assessed only by a diverse group of health care providers. Without involving these individuals in the review process, we limit the scope of information necessary to make decisions regarding both the cost and quality of health service." (Partridge, 1974)

According to Miller, in the October 1, 1975, issue of *Nursing* "The PSRO law as presently written may herald the demise of the expanded role of the nurse as well as professional nursing as we know it. Instead of the number of nurses in expanded roles increasing, nurses could be forced to continue to play handmaiden roles. By PSRO's restricting nursing practice in the areas of independence, and decision making, there may be no real function for nurses!" (Miller, 1975) This position may be extreme, but there is enough truth in his warning that should alert nursing to the hazards ahead.

Many physicians and nurses who support patient care audits often wish they could avoid the prospect of writing audit criteria, and we can appreciate their reluctance. First it is time consuming for professionals to describe in detail the optimal care for patients with a particular diagnosis, surgical, or special procedure. Perhaps just as important a reason is that written audit criteria come out sounding like "cookbook patient care" and physicians or nurses may feel that written criteria will take away the freedom to make clinical judgments about individual cases. Perhaps even more important, however, is that sometimes we are not sure in the health care field exactly what it is that we do that makes a difference in the outcomes and that having to write criteria in black and white makes us realize how little scientific information we have about our work.

Thus, although audit processes in nursing have been established which can handle some of the accountability questions, we have not been able to deal adequately yet with the scientific validity question, nor have we been able to validate humanism satisfactorily in health care. Now we have PSRO's which will attempt to set legal parameters around some of these questions without nurses being active partners in the process.

Summary and Conclusions

Having started on this long and arduous journey through ideas of accountability, accountability systems, humanism in accountability, dilemmas of nursing as a profession, problems of the scientific basis of practice, the problems of patient care audits, and the threat of PSRO's to nursing and its expanded functions, I wonder how many of you I have left along the way because the journey was too tiresome or perhaps the starting time too early.

The journey here may have been difficult because of your guide's selection of the route, but it is clear that the journey is no less rigorous in real life if there is to be true accountability in the nursing profession.

What I am left wondering, however, is my original question—"Accountability to whom for what?"

I guess it is clear, that nurses must be accountable to society that has given them their charters—the nurse practice acts—to practice. They must be accountable to their institutions for whom they work. They must be accountable to their profession. They must be accountable to themselves.

The remainder of the 20th century, however, should be a time for nursing to become accountable for perhaps the most important thing of all—that is for the self actualization of the profession.

– This means closing the gaps in the scientific basis of practice.

– It means taking a stand on humanism in nursing whether you can audit it or not.

– It means most importantly standing up for nursing rights.

Claire Fagin reminds us in the January issue of the *American Journal of Nursing*, "The New York State Nurse Practice Act states that 'nursing is diagnosing and treating human responses to actual or potential health problems, through such services as case finding, health teaching, health counseling, and initiation of health care.' There is power and leverage within this definition. Yet few nurses have so far shown evidence of grasping this inherent power and using it effectively. Nurses, for the most part, play the role described earlier of all women—submissive, dependent, indirect, and frightened. Failure to act on behalf of our rights increases our guilt and low self-esteem and compounds our problems by discouraging the development of enabling behaviors to achieve rights. In seeking security, rather than satisfaction, we are, more often than not, unaware of our lack of achievements. Many of our constituents view their jobs as eight hours of drudgery leading, hopefully, to satisfactions in other areas of life separated from work. In this process we lose the benefits of years of education, our original motivation in becoming nurses, and the potential value of most of our awake lives.

"Rather than face this misery openly and honestly we have found it much easier to focus on the responsibilities we ought to have and not have. We are more likely to blame others for the fact that we are not able to carry out the responsibilities we describe in our own nursing literature or in the resolutions quoted earlier. Unfortunately, in this blaming of others, we contribute to the alienation of professionals from each other and towards an ever expanding gulf of hostility and noncommunication. This is not living, no less professional practice. The highest order of responsibility in our priority system should be the responsibility of seeing, through unified action, that our rights are obtained. Leadership in our educational and work situations is required in order to revise the socialization process of nurses and others towards active participation and self-realization. Rigid bureaucratic settings do not encourage active participation. Nor, however, do educational settings which claim to have eliminated the trappings of bureaucracy but through covert and overt messages encourage adjustment and adaptation rather than growth and learning. It behooves us all to examine the conditions of our professional lives in order to ferret out those which inhibit self-enhancement and capitalize on aspects which will encourage our goal of advancing nurse's rights." (Fagen, 1975)

Although the focus of this talk has been primarily on professional accountability, it is obvious that we cannot do what our institutions prevent us from doing or do not support us in doing. Institutional support for development of accountability systems is a key element in what happens but even these can be changed. Perhaps even more important, for those of us here, however, is what we personally do about accountability. In closing let me leave you with a little poem by an unknown author, which hopefully brings accountability to the most important level of all—

The Nurse in the Glass

When you get what you want in your struggle for self,
And the world makes you queen for a day,
Just go to the mirror and look at yourself,
And see what *that* nurse has to say.

For it isn't your father or mother or boss,
Upon whose judgement you must pass,
The one whose verdict counts most, gain or loss,
Is the nurse staring back from the glass.

She's the person to please, never mind all the rest,
For she's with you clear up to the end.
And you've passed your most dangerous, difficult test,
If the nurse in the glass is your friend.

You may fool the whole world down the pathway of life,
And get pats on your back as you pass,
But your final reward will be heartaches and tears,
If you cheated the nurse in the glass.

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APPLICATION OF SYSTEMS CONCEPTS TO HEALTH SERVICES MANAGEMENT

by

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I. Purpose

This paper is designed to demonstrate, briefly, how the concepts of systems theory can be adapted effectively to the process of managing health services organizations.

It begins by discussing the relevant concepts and defining them in familiar terms. This section provides a common base of knowledge and a vocabulary which is used in the remainder of the paper.

The next, and major, portion of the paper describes a sequence of five processes which are required for the management of a system. These are:

1. Setting general goals
2. Defining the subsystems
3. Describing the subsystems
4. Monitoring system performance
5. Adjusting the system

The final section identifies a number of important elements of systems management that could not be incorporated into this brief introductory paper. The aim of this section is to alert the reader to some additional procedures which can be developed to expand the limited, basic process outlined in this paper.

II. Systems Concepts

A. General Definition

A system is a set of elements linked together in a purposeful way to convert inputs into outputs. In slightly different terms, a system is a group of appropriate components which have been organized to work together so that they can use available resources to create desired products or services.

B. Basis of the Systems Approach

The systems approach is designed to overcome the problems which are inherent in traditional, fragmented problem solving. Specifically the systems approach provides the following advantages.

First, the systems approach requires an analysis of the entire system that can lead to a better diagnosis of problems. In the fragmented approach, the problem solver deals with the immediately evident source of difficulty. This is frequently equivalent to treating a symptom rather than curing a disease. It generally leads to the SMOTS (Some more of the Same) type of solution which is frequently inappropriate. For instance, an excessive occupancy rate in an acute care hospital might be reduced by adding costly acute care beds when, in fact, a less expensive and more desirable solution might be found by examining the interaction between the hospital and other parts of the system. An obvious possibility in this simple example would be to consider transferring post-acute patients to an extended care facility.

Second, the systems approach enables the manager to consider the total impact of his or her decisions.* Even after one has focused corrective action on the fundamental problem, one generally has a range of alternatives from which to choose. Any action taken is likely to affect other parts of the system as well as the problem area on which it is focused; therefore, the decision-maker should consider the net results (costs and benefits) of the multiple effects of each alternative before making the choice. For instance, a change in drug dispensing procedures may make a substantial improvement in the medication process, but it also could lead to improvements or difficulties in the financial accounting system.

The perceptive reader will quickly recognize that there are important problems associated with the use of the systems approach as it has been described so far. It would seem to require the decision-maker to know everything about everything. This, in fact, is a simplified statement of the major criticisms levelled at the systems approach. The critics carry the process to its ultimate lengths which are clearly beyond the capabilities of decision makers. The advocates of the systems approach demonstrate its pragmatic feasibility by adopting two concepts, boundaries and mixed-scanning. These ideas, which are defined in the next section, allow the decision-maker to limit the scope and quantity of information with which he must deal.

C. Systems Terms

1. Hierarchy of Systems. Each system is part of a larger system and is itself comprised of smaller systems which are called subsystems. Thus, if a person is a system he is part of a group which is part of a community which is part of a town, etc., etc. At the same time, each person is comprised of physiological systems (e.g., nervous system) which are comprised of smaller systems (e.g., brain).

2. Boundary. The line of demarcation between the system of interest and the remainder of the universe. Boundaries are established by decision-makers to encompass all of the relevant components of the system.

3. Environment. The universe outside the boundary of the system. Environment as used here is clearly different from the physical environment (e.g., air, water, noise) which is often of special concern to health professionals.

4. Boundary Conditions. The relationships which exist between the system and the components of its environment. For example, how do information and materials flow between a pathology laboratory and the remainder of the hospital.

5. Black Box. The elemental unit of a system. A sub-system which the decision-maker treats as a processing unit whose internal operations are of no interest. In other words, the decision-maker pays attention to only the inputs, outputs, and externally observable operating characteristics. For instance, many people treat an automobile as a black box which converts an input, gasoline, into an output, transportation, and exhibits certain operating characteristics (e.g., rate of acceleration) while doing so.

Although the majority of the audience of this paper will be women, I wish to avoid sex stereotyping of occupational jobs; therefore, in the remainder of the paper I will use masculine pronouns in keeping with the tradition that they are the English equivalent of a neuter gender.

6. Input. The resources (people, buildings, equipment, money, knowledge, etc.) used by a system to create outputs.

7. Output. The product or service created by the interaction of the system components using the inputs provided.

8. Attributes. The characteristics of the system. A system can be described fully in terms of attributes related to inputs, outputs, operating characteristics and constraints. An attribute of a medical care system might be quality.

9. Criterion. An operational definition of an attribute; i.e., a restatement of an attribute in terms of observable occurrences. Often there will be many criteria for each attribute. For example, infection rate and accreditation by Joint Commission on Accreditation of Hospitals, JCAH, might be quality criteria for a hospital.

10. Standard. The acceptable level of performance related to a specific criterion. A standard may be a single amount, a range of values or a simple positive or negative result. To illustrate: a 2% infection rate, an average length of stay between 4 and 8 days, or renewal of accreditation.

11. Controller. A component of the system which compares data on system input, operation and output to standards for the purpose of adjusting system performance toward achievement of the least possible discrepancy between performance and standard. The control process is often called evaluation.

12. Feedback. Data concerning system performance which is sent into the controller. Also correction signals from the controller to the components of the system.

13. Feedforward. Data concerning the future state of the environment and the system which are sent into the controller. Feedback into the controller reports only historical conditions; thus, adjustments based on feedback alone assume that future conditions will be the same as the past. A feedforward mechanism allows the system to adapt its performance to both past experience and forecasted future circumstances.

14. Open system. A system that interacts with its environment. This is a more realistic model (representation) of an organization than the closed system model which frequently is implied by traditional management literature. (See Figure 1).

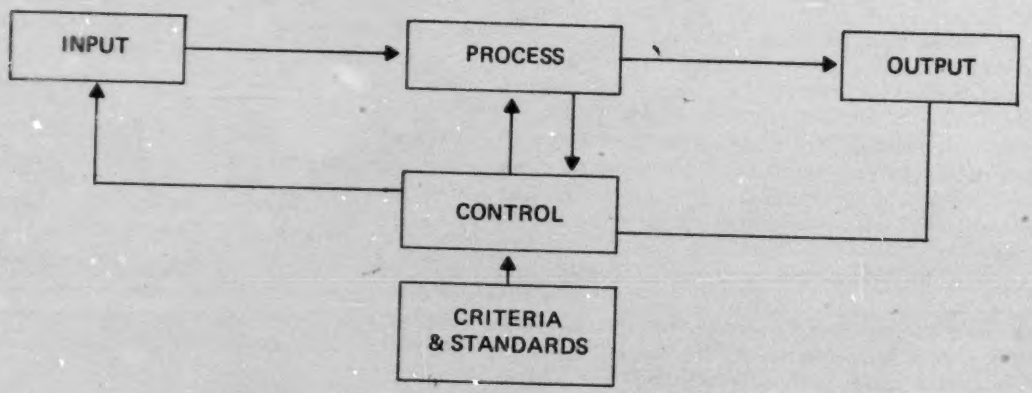
15. Entropy. A movement toward disorder, lack of resources, transformation and stagnation. Open systems import information, resources and energy to withstand the tendency toward entropy. Sometimes these imports are sufficient to increase organization and order. This condition is called negentropy.

16. Steady state. All systems work toward equilibrium. In a completely closed system, this would be entropy. An open system can attain dynamic equilibrium.

17. Equifinality. The ability to achieve the same result with different inputs, different processes or both. This implies the existence of a significant degree of flexibility and adaptability in contrast to a mechanical, one best way approach.

18. Mixed Scanning. A strategy for dealing with large, complex systems without overloading the information processing capability of the decision-maker. In essence, the decision-maker selects a subsystem of particular interest and describes it in great detail while data on the remainder of the system and on the environment are reported in only enough detail to provide a context within which the subsystem of interest can be examined effectively.

CLOSED SYSTEM



OPEN SYSTEM

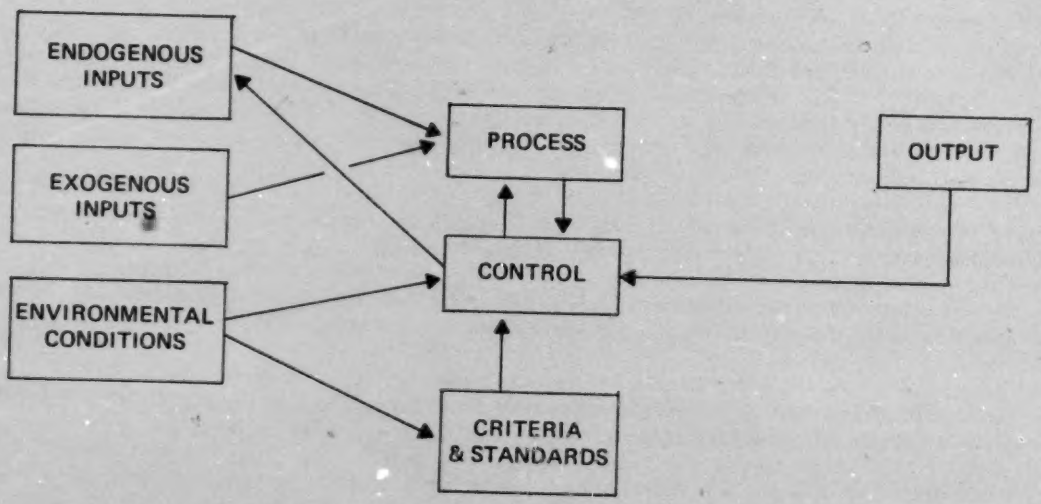


Figure I OPEN AND CLOSED SYSTEMS

D. Illustrative Systems

Two examples will be given to illustrate many of the terms just defined. The first will be generally familiar, but not associated with the readers' occupation. This should avoid the value biases that invariably creep into perceptions of ideas which are important to the reader. The second example will be taken from the health services field to overcome the problem of irrelevancy that may obscure the significance of parts of the first illustration.

1. The automobile. The automobile is a subsystem within a larger transportation system. Its boundaries are clearly defined by its physical shape. The boundary conditions are established by traffic laws and the rules of the road. Generally the user treats the entire machine as a black box with gasoline as the major input and transportation of people as the most significant output.

Many of the criteria and standards are created within the environment (e.g., speed limits) but others are internal (e.g., the driver may have a very long or very short list of factors which he considers relevant to the evaluation of an auto's performance). The controller is the driver who receives feedback data from a variety of sources such as the speedometer. The controller also gets a fair amount of feedforward data especially from traffic warning signs (e.g., sharp curve ahead).

The controller and decision-maker also uses a mixed scanning strategy in dealing with the multiple subsystems while driving. Even though he may be a skilled mechanic who is intimately familiar with the parts of the engine, we hope that he focuses his attention on the details of the guidance system and considers such things as operation of the carburator only to the extent necessary to determine that the engine is running smoothly.

2. The prenatal clinic. The prenatal clinic is a subsystem within a larger health services delivery organization, such as a public health department. It may have physical boundaries if a particular space in a building is allocated for its use. It will surely have functional boundaries dictated by the nature of its clientele. Other clinics (e.g., internal medicine) may have much fuzzier functional boundaries. Boundary conditions are established by organizational policies, procedures, and customs. The Public Health Officer may see the clinic as a black box and consider physician and nurse efforts as the major input. Probably counselling and treatment of pregnant women will be regarded as the output.

Formal criteria and standards will be externally imposed (e.g., state laws, federal guidelines on maternal and child health programs, etc.), but there may be many informal criteria as well (e.g., accepted medical practices). The controller is the head of the clinic who may obtain feedback from some sort of a management information system as well as from his personal observations of the clinic operations. There probably is no formal system for acquiring feedforward data about the future conditions in which the clinic will be operating.

Whether or not the Public Health Officer will treat the prenatal clinic as a black box will depend upon his individual style of management and the nature of the issues. For instance, he generally may regard this and all other clinics as black boxes and leave detailed management entirely in the hands of the clinic director; however, in the event of a sudden increase in the infant mortality rate, he may find it necessary to require much more detailed data on the oepration of this and other subsystems that could contribute to a reduction in the number of infant deaths.

III. Applying Systems Concepts

This section will describe the application of systems concepts to the management process as a sequence of five major steps. This model of discrete steps is a convenient fiction which serves to clarify the explanation of the method. However, in reality the process will be a very "messy" one in which there will be many occasions when it

will be necessary to go back to earlier steps in order to revise prior decisions because of knowledge gained while attempting to implement those decisions. In jargon, this is called an iterative process. The decision-maker must bear the nature of the iterative process in mind so that he will not use an inordinate amount of time or resources seeking "perfect" information in the initial steps. Similarly, he should not develop an overcommitment to early decisions.

A. Setting General Goals

1. Reasons for general goal statements.

It is frequently assumed that mutually consistent actions (e.g., votes) by a number of people are indicative of the existence of commonly shared values and beliefs. A little reflection will reveal quickly that this is indeed a weak premise upon which to base organizational procedures. In other words, there is an almost equally great probability that people have acted in the same way for very different reasons. For instance, people who are labelled as liberals and conservatives might both support a negative income tax, but the basis for support could be contradictory.

An organization which does not develop a statement of its general goals implicitly accepts this questionable assumption. Within such an organization each person will interpret each of these outcomes in a way which is favorable to his point of view and use this as a precedent to guide future actions. Clearly such a situation is an open invitation to organizational chaos.

Second, most organizations experience a significant amount of staff turnover. Even if the consensus assumption is valid, new members of the team lack the institutional memory necessary for implementing the consensus in their activities. Consequently in the absence of a formal statement of goals, each new person must spend a great deal of time and effort searching for guidelines.

2. Content of general goal statements.

The general goal statements should both reveal the overall managerial philosophy of the organization and identify the key attributes of the system and its subsystems.

The overall managerial philosophy should address at least the following points:

a. role(s) of the organization

b. boundaries of the system with which the organization is concerned

c. time values of the organization (i.e., is immediate result preferred to long-run payoff)

d. style of change preferred (incremental shifts vs. abrupt major redirections)

e. level of risk which is acceptable

f. basic values and their relative priorities (e.g., equity, equality, efficiency)

g. assumptions about resources availability

h. assumptions about the future, and

i. the theory on which the organizations activities are based (e.g., which approach to mental health is favored by a "psychiatric" hospital)

Obviously, the preceding list is not arranged in any sort of priority sequence. Also, it is illustrative rather than exhaustive.

The second portion of the general goal statement will deal more directly with the substance of the organization's mission. It will state in broad terms what the organization wishes to accomplish and how it should carry out its functions. In slightly different terms, this segment of the goal statement will describe the system's attributes. These attributes are of critical importance because they define the characteristics of the system which management considers to be relevant in making decisions about the system. Thus, for example, the manager of a health system might be concerned with acceptability, availability, quality and cost but would exclude competitive advantage and product obsolescence from his list of decision-variables.

3. Nature of general goal statements.

As the title implies, goal statements at this level must be very broad and general in nature. Since these statements provide a description of the total system, the degree of generality will vary with the nature of the subsystems because each goal statement should apply to all components of the system. If, then, the subsystems are very heterogenous only rather broad statements can apply to all with equal force. At the other extreme of the system comprised of a single subsystem, the goal statements could be as definitive as criteria and standards.

B. Defining the Subsystems

1. Purpose of defining subsystems.

The boundary descriptions in the general goal statements set the outer limits of the system. In most cases, the system within these bounds will be too complex and/or too large to be managed as a single entity. Part of this problem was alluded to in the preceding discussion of goal statements. In other words, if a system is so heterogenous that it can be described only in general terms, the manager will lack the definitive guidelines required for effective control unless he deals with each subsystem separately. This means, then, that in addition to defining the scope of the system, the manager must also identify the system's components as subsystems which are sufficiently homogenous to permit precise definitions of the characteristics of each.

2. General rules for subsystem definition.

These two rules are simple, but quite important.

First, the set of subsystems identified must be exhaustive. In other words, the subsystem list must include all parts of the system.

Second, the subsystems identified must be mutually exclusive. If some part of the system falls within two or more subsystems, the manager will be unable to assign responsibilities, allocate resources, etc., on the basis of the system's organization. In practice, this is a difficult rule to follow and frequently the manager will have to allocate components to one subsystem or another on a fairly arbitrary basis. For instance, if a community health system had an ambulatory care subsystem and a long-term care subsystem, it would be difficult to decide in which of these two home health care of the chronically ill should be placed.

3. The hierarchy of systems.

The preceding discussion suggests that the manager must eventually develop an exhaustive and mutually exclusive list of the system's elements or black boxes. Perhaps it would be possible to simply draw up such a list by thinking of potential elements. It seems, however, that there would be little likelihood that such a list would meet the two criteria. Consequently, we must look for a more systematic approach.

The concept of a hierarchy of systems offers a solution. Specifically we can, by a process of analysis of subsystems, develop lists of even smaller system components until we have reached the level which the manager wishes to treat as a set of black boxes. Figure II is an illustration of how a community health system could be divided into subsystems.

Figure II shows that at each level the entire system is divided into exhaustive and mutually exclusive subsystems by subdividing each of the subsystems of the higher level. In this example the manager determined that subsystems at Level IV would be dealt with as black boxes.

The figure also clearly implies a systematic basis for division at each level. This basis can be called an organizing principle. Some commonly used organizing principles are intensiveness of care, site of performance, kinds of equipment required, and characteristics of the clientele.

4. Criteria for selecting an organizing principle.

The preceding examples of organizing principles should make it evident that the manager will be able to devise a large number of alternatives. The potential strengths of each may vary from situation to situation; i.e., one alternative may be better suited to a specific management need than another. The following criteria are offered to aid the manager in choosing among the alternatives.

a. Are data collected on this basis? For example, do information systems distinguish between long-term and short-term patients?

b. Is the organizing principle compatible with the formal structure of the organization?

c. Is the organizing principle compatible with the physical or geographic distribution of the organization's components?

d. Is the organizing principle compatible with the categories of patients served?

e. Is the organizing principle relevant to the types of resources which must be allocated by management?

Although these criteria are not necessarily mutually exclusive, there is a high probability that they will lead to conflicting alternatives in many situations. When this occurs the manager will designate black boxes on the basis of his dominant concerns. However, it is possible for the manager to further divide the black boxes on the basis of the other concerns not included in the primary organizing principle. This would allow the manager to aggregate data about subsystems on the basis of alternative organizing principles.

For instance, if black boxes are chosen on the basis of organizational structure when the manager is also concerned with physical location and patient types, it would be possible to collect data on the basis of all three dimensions. For instance, if there are 2 organizational components (I and II), 2 service sites (A and B) and 2 patient types (Y and Z), there would be 8 groups of data about black boxes. These groups would have the following pattern.

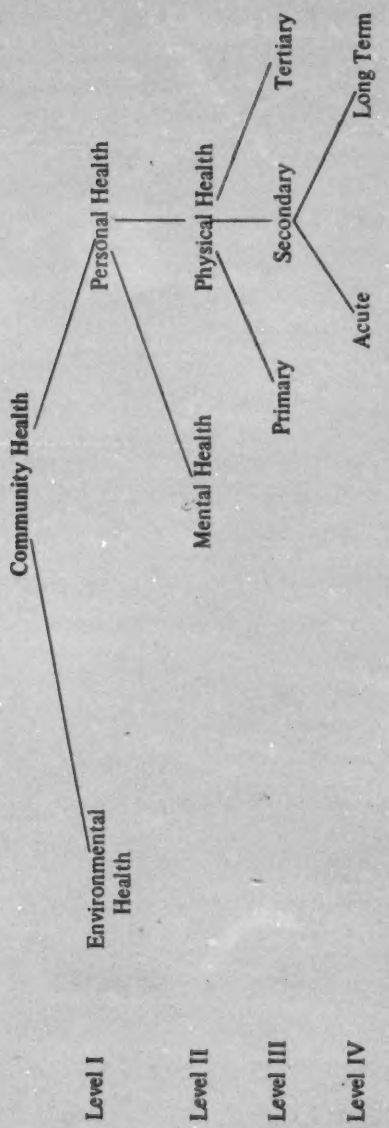


Figure II: Illustrative Four-level Analysis of Community Health Subsystems

Organization	Site	Patient Type	Value ($000)
I	A	Y	$4
I	A	Z	$3
I	B	Y	$2
I	B	Z	$5
II	A	Y	$7
II	A	Z	$3
II	B	Y	$3
II	B	Z	$5

In this example, the manager could aggregate the value data on any of the three dimensions as follows.

Dimensions	Values ($000)	
Organization	I = $14	II = $18
Site	A = $17	B = $15
Patient Type	Y = $16	Z = $16

Describing the Subsystems

1. Purposes of describing subsystems.

The general goal statements provide an overall description of the system. However, as stated earlier, these statements are not sufficiently specific for the management of individual black boxes. Setting goals, evaluating performance and allocating resources requires precise, objective statements concerning each subsystem. The general goal statements indicate the system characteristics which management considers important for decision-making. The present task is to translate those general statements into specific items which are applicable to individual subsystems. In other words, criteria must be derived from each goal statement.

2. Development of Criteria.

A criterion is one operational definition of a systems attribute; consequently, most goal statements will lead to the development of several criteria. Some criteria will apply to all subsystems; others will be inappropriate for certain subsystems. Figure III illustrates these ideas for the attribute, Accessibility.

	Criteria		
Subsystems	Travel Time from Residence	Hours of Operation	Bi-lingual Staff
Outpatient Care	X	X	X
Inpatient Care	X		X
Laboratory	X	X	

X indicates criterion relevant for this subsystem

Figure III: Accessibility Criteria for 3 Subsystems

In this illustration, hours of operation are not relevant to the inpatient care subsystem since it is assumed to be a 24 hour per day activity. Bilingual staffing may not be a barrier to use of the laboratory since services will be provided on the basis of written instructions from the physician.

Criteria can be developed by an individual working independently if such person knows the system intimately. However, experience has shown that a group process usually produces a more complete list of criteria and may, also, be more rapid than research by a single person.

Regardless of the method used, the criteria must relate to observable occurrences since this is essential for preparation of standards.

3. Development of Standards.

Criteria, it can be argued, may be developed on a centralized basis since they will be relevant to all similar subsystems. For instance, the same criteria apply to emergency medical services (EMS) in both New York and New Mexico. Standards, however, are situationally specific and thus must be developed on a decentralized basis. To continue with the EMS example, the acceptable level of response time in New York City may be physically unattainable in rural parts of New Mexico. In addition to such physical limitations, standards may vary widely because of local differences in the amount of resources available for a particular subsystem.

Development, *de novo*, of technical standards for each subsystem could be tremendously costly since the establishment of these specific values requires a high level of expert knowledge or at least a substantial amount of research. Consequently, it is suggested that technical standards be developed centrally and the results presented in such a way that they can be adapted to local resources and local values.

Not all standards will be susceptible to technical analysis. Some will be purely judgmental. In such a case, standards could be developed through a process, similar to Delphi,* in which members of the affected groups can contribute to a collective decision.

4. Analysis of goals.

Setting standards implies the establishment of specific goals concerning the resources utilization, operation, and production of each black box or subsystem. It is at this point where one of the most powerful aspects of the systems approach comes into play.

Fragmented systems are notorious for their tendency to seek maximization rather than optimum results. It is easy to criticize the maximizers. However, in most organizations a complete conversion from maximizers to optimizers would have little effect (except to frustrate the converts) because there is no systematic way by which interactions can be identified and analyzed.

The approach proposed in this paper provides a means for interaction identification. Methods for analysis of interactions will vary from case to case ranging from rigorous techniques such as mathematical programming to completely subjective judgments. The rigorous techniques will require homogeneity of data across subsystems (you cannot add apples and oranges) but this similarity should not be pursued too vigorously when establishing criteria. If, coincidentally, all subsystems have a criterion dealing with registered nurse working hours, that is fine and it may permit use of some fairly sophisticated methods. However, that is far less important than describing subsystems in such a way that it is feasible to examine the amount of symbiosis between subsystems. For instance, we cannot add the number of nursing home beds and the number of acute hospital beds; but, from the perspective of the community, the important point is the balance between these resources rather than some artificial aggregative value such as total dollars invested in inpatient beds.

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*See Helmer, Olaf "Analysis of the Future. The Delphi Method" in Bright, James R., ed., *Technological Forecasting for Industry and Government*. Englewood Cliffs, N.J., Prentice-Hall, 1968, pp. 116-122.

The interaction identification process relies upon two characteristics of the systems approach. Exhaustive identification of all system components and consistency of the attributes used in describing all subsystems. These characteristics allow us to construct a two dimensional matrix as shown in Figure IV.

Attributes:	Availability			Accessibility			Quantity		Cost		Etc.
Criteria: / Subsystems	Service Capacity	Etc.		Distance from Patients' Residence	Hours of Operation	Etc.	Staff/Ptnt. Ratio	Etc.	Charges per ptnt. day	Etc.	
Emergency Medical Services											
Acute Inpatient Care	2						3		3		
Nursing Home Care	X			1			1		1		
Mental Health In-Patient	2						3				

Figure IV: Goal Interaction Analysis Matrix

The purpose of this matrix is simply to provide an heuristic device for the identification of potential interactions between goals or between decisions and other aspects of the subsystems. The approach is the same in either case. The objective is to alert the decision-maker to the fact that any decision is very likely to have significant impacts on parts of the system which are remote from the focus of the decision. This relates to the concept of system-wide optimization, but the device will also help subsystem maximizers to avoid the oversights of which they often have been guilty.

The use of the matrix can be demonstrated by a simple example. In this case, a decision has been made to increase the capacity of the nursing home subsystem by building an additional institution. This may lead to primary effects within that subsystem. The new institution should put nursing home beds closer to some portion of the population; if there is a manpower shortage, patient-staff ratios may decline; and the increased competition may affect charges. There will probably be secondary effects on the availability of acute inpatient care and inpatient mental health care. In the first case, the nursing homes might make it feasible to transfer convalescent patients from acute care beds. In the case of mental hospitals it might become possible to keep indigent, elderly patients who are not capable of complete self-maintenance in their community rather than committing them to remote mental hospitals for custodial care. Also tertiary effects may arise from the secondary effects just described. The patient/staff ratio might change in both subsystems. Charges might be affected by lower occupancy in acute hospitals. Since mental hospitals budget differently they would probably not experience a similar change.

The alert reader will notice quickly that this analysis could be extended in many ways. For instance, the primary effect of changed charges in nursing homes might also affect the charges for acute hospital care. This brings up once more the criticism that the systems approach requires the decision-maker to know everything about everything. Again, we respond that the decision-maker's judgement can lead easily to an effective balance between costs, comprehensiveness, and usefulness.

D. Monitoring System Performance

This section will deal with two aspects of system performance monitoring. The first is the collection of the required data. The second is the use of the data in the evaluation process.

1. Data collection.

In order to monitor the performance of a system, the decision-maker needs a mechanism to collect data at different points in the system and to build an historical data base. (Data collected at a single point in time are insufficient for the sophisticated decision-maker. Direction of change and rate of change are, for him, of equal importance with current status.) In other words, he must develop a management information system (MIS).

It is beyond the scope of this paper to describe the development of an MIS or even to discuss the large volume of literature concerning this topic. But it is important to point out that one of the most difficult problems in design of information systems is solved by the systems approach as it has been described.

Very few of the standard texts offer a specific approach to the determination of the content of the information system; instead they concentrate on the details of constructing files, collecting and communicating data and generating reports. Generally the system designer is exhorted to be certain that the data are relevant to the needs of decision-makers, but how he is to achieve that end remains unstated. In contrast, the systems approach leads to the development of a set of criteria from general goal statements which identify all the system attributes which decision-makers consider to be significant. The decision-maker also develops an exhaustive list of system components which are to be described by these attributes. Thus the combination of an exhaustive list of system components and a comprehensive statement of relevant criteria, provides a complete yet parsimonious definition of the required data base contents.

2. Evaluation.

Evaluation is the process of making a comparison between data which report what has occurred and the standards which decision-makers have approved. These comparisons usually focus on four aspects of system performance.

a. Effort – what amounts of resources has the system used?

b. Effect – what has the system achieved, how has the system operated?

c. Impact – how does the system's actual achievement relate to the total need for the product or service?

d. Efficiency – how much has the system achieved in relation to the value of the resources consumed?

Each of these aspects is addressed explicitly or implicitly by the criteria and standards. Effort is explicitly treated by the criteria related to input quantities. Effects are dealt with by performance criteria and by output criteria. If output standards are based upon a thorough analysis of subsystem interactions, they will implicitly consider Impact. Similarly, the intra-subsystem interaction analysis will have led to a desired balance between input values and level of outputs even though such a balance is not explicitly listed among the criteria.

One problem inherent in the evaluation process is the inability to measure all results on the same schedule. Generally inputs and intermediate outputs (e.g., amount of service provided) can be measured almost immediately. On the other hand, final output (e.g., change in patient's quality of life) may not be evident for

months or even years. Because of this difficulty an evaluation process should include a capacity to deal with several different time frames. At a minimum, short-run and long-range (defined according to system performance schedules) evaluation should be planned.

Planning is an important aspect of any successful evaluation program. Evaluation is essentially retrospective analysis and such analysis cannot be done unless the relevant data have been systematically collected and stored. Thus it is essential that the evaluation component be designed and implemented concurrently with the operating system which is to be evaluated.

E. Adjusting the System

1. Feedback.

Seldom, if ever, will even the most carefully designed system achieve continuous perfect performance. In fact, it is much more realistic to anticipate that actual system performance will deviate from what is desired. Given this expectation, it then becomes necessary to have a means of minimizing the deviations between actual and desired performance. This is the purpose of the controller.

In the simplest model of a system, the controller first receives feedback data from the evaluation process. Next it examines the reported deviations to determine whether they are indicative of serious performance problems. A deviation might not be considered as a serious problem for instance if it was simply a minor, random variation within established boundaries of acceptable values on either side of the desired performance level. This situation is illustrated by the X's in Figure V. Also a deviation might not require corrective action if it suggests that a trend toward the desired level exists. The O's in Figure V are an example of such a case. In other words, "no change" may be a completely acceptable decision.

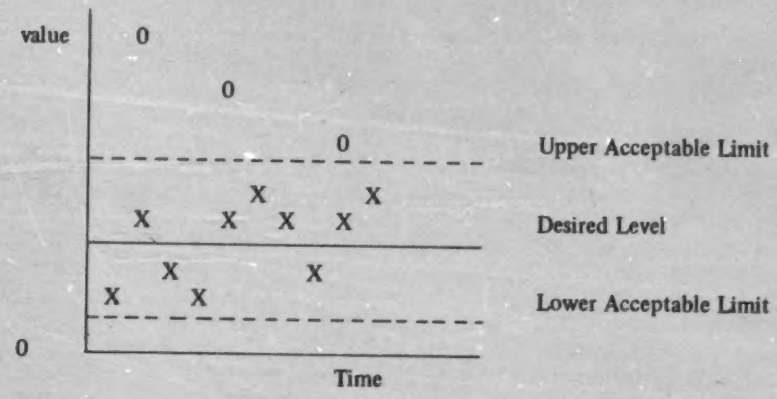
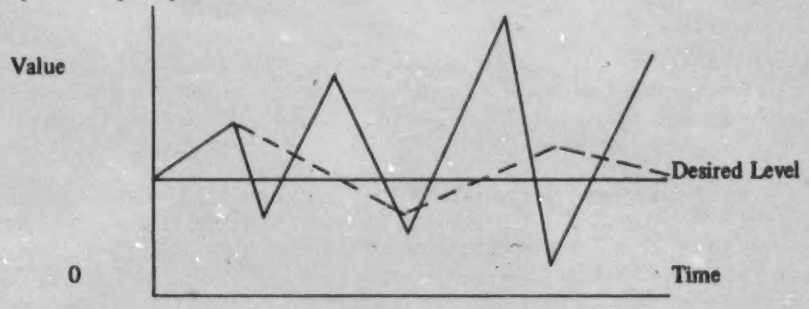


Figure V: Illustrative Control Chart

However, when it is evident that current performance is unsatisfactory, the controller must modify the system's input or operating characteristics in some way which is likely to bring performance closer to the desired level. In a simple system such as the airplane's autopilot, the choice of an adjustment from among the available alternatives can be a rather straightforward, mechanical process. In more complex systems, especially those

involving human beings, the controller must go through an extensive analysis to identify the causative factors and must exercise judgment in choosing the appropriate response.

Unfortunately, the controller is subjected to two countervailing pressures. Clearly the more thorough the analysis, the better the quality of the information. But, greater thoroughness implies more time. On the other hand, the longer the deviation persists, the greater it becomes and thus the corrective action must be more intense. But, greater intensity of corrective action increases the danger of overcorrecting; consequently delay in making adjustments may lead to development of opposite, but equally undesirable, deviations. In fact, the situation may become explosive as when overreaction to a relatively small swerve of an automobile may put the vehicle into an uncontrollable skid. See Figure VI. The latter consideration also indicates a need for providing the controller with frequent and prompt feedback.



——— Overractions Path

– – – Controlled Adjustments Path

Figure VI: Illustrative Comparison between Overreactions and Controlled Adjustments

2. Feedforward.

Feedback is necessarily historical data. Consequently, adjustment made solely on the basis of feedback implies an assumption that the historical conditions in which the system was performing will persist into the future.

Feedforward is the process of collecting data that will allow the decision-maker to confirm or refute the historical assumption. If this assumption is confirmed, then the feedback-based adjustments are acceptable. If not, the controller must modify the planned adjustments in order to accommodate the anticipated changes in the system's environment.

IV. Additional Considerations

The preceding sections have dealt with certain key concepts which are relevant to the systems approach to management. These concepts are the fundamentals necessary for a manager to adopt the approach, but clearly there are numerous related ideas which can be added to the approach to increase its effectiveness. This section contains brief discussion of three of the major issues which are likely to be of particular importance to the manager. They are other system functions, roles of participants and planning.

A. Other System Functions

The system model presented in this paper has shown the system only as a producer of goods or services. (This production function will be called goal achievement.) As a matter of fact, however, a system must perform four functions to survive. These are:

1. Goal achievement
2. Resources acquisition
3. Internal coordination
4. Environmental adaptation

Each of these can be regarded as a separate subsystem within the larger organizational system. This constellation of subsystems is guided toward the desired end by the policy statements which express the overall purposes of the entire system. (See Figure VII).

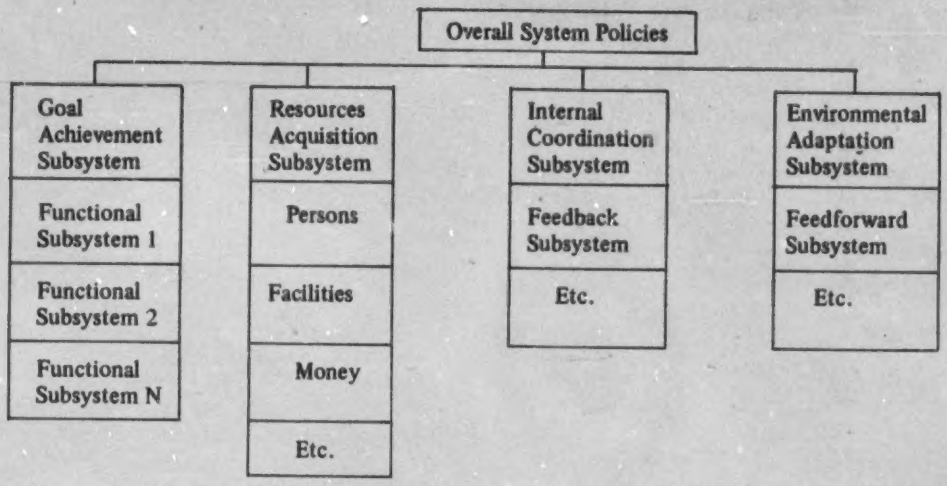


Figure VII: System with Subsystem for Each of 4 System Functions

A system cannot carry out its purposes unless it can maintain a steady flow of the resources required to operate the system and as inputs into the goal achievement process. These resources will include people, money, facilities, and equipment. In all probability, a separate subsubsystem will be required for each resource category.

Internal coordination implies an attempt to balance the operations of the four subsystems. The persons responsible for each subsystem have a natural tendency to maximize the output from "their" subsystems. Since there are never enough resources to permit this sort of behavior on the part of all subsystems, the internal coordination has a major responsibility for seeking an optimal level of operation for each of the subsystems. It

of course also deals with internal communication between subsystems and with integration of subsystem functions. The feedback loop or internal management information system (MIS) is a major component of this subsystem.

Environmental adaptation addresses the need for exchange relationships between the system and its environment. This must be a bilateral arrangement. The system must frequently modify its behavior to accommodate the needs of other systems in its environment. It must also induce or coerce the other systems to adjust their operation if the existing mode of operation produces results which are detrimental to its (the basic system's) purposes. Feedforward or an external MIS is a component of this subsystem.

B. Roles of Participants

No attempt has been made to assign the various activities described to persons who participate in the system's functioning. For example, who is involved in establishment of policies? For purposes of this brief discussion, three kinds of participants can be identified: system manager, subsystem manager, and system's client.

If it is assumed that the system manager is the ultimate decision-maker, then he must allocate responsibility between himself and subsystem managers. The concept of the black box may aid in successful delegation of responsibilities (i.e., avoidance of intervention in the activities of subsystem managers). This same concept is particularly useful in establishing a process of management by objectives (MBO). Furthermore, the policy statements provide a context within which subsystem managers can establish their initial statements of objectives.

The role of the client becomes an especially crucial issue when dealing with a professionalized system such as medicine. By definition, a professional has special knowledge which the client lacks. By implication, the client and professionals have differing values and expectations. Also, the professional exercises control over all of the inputs to the processor part of the system except for client behavior which is influenced most strongly by the clients' expectations. Consequently, given two sets of expectations influenceing different segments of the input, there is a high probability of incompatibility between inputs. In the medical field this is often manifested as patient non-compliance. Figure VIII illustrates this situation.

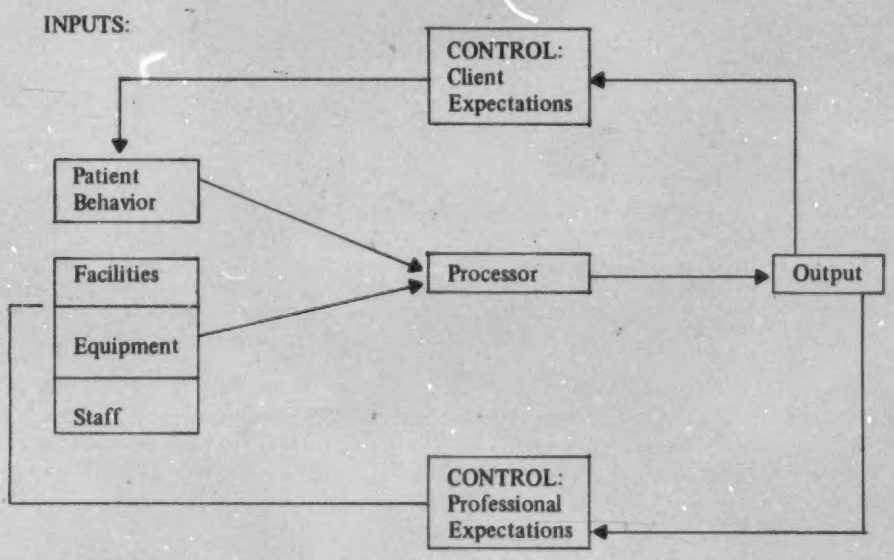


Figure VIII: System with Dual Controls

C. Planning

The systems approach described in this paper has focused on management of current operations, but it can be readily extended to meet the requirements of a long range planning process.

To do this it is first necessary to set general goals, criteria and standards for the planning horizon (i.e., the point in time at which the purposes of the plan are expected to be achieved). The next step is to forecast what the system would be like at the planning horizon if it were allowed to continue its current operation without intervention. Third, comparison of the forecast with the standards is made to reveal disparities. The elimination of these disparities becomes the set of long-range goals. Each long-range goal can be achieved by a set of intermediate actions (objectives) spread over the period from the present to the planning horizon. Setting objectives is the fourth step. Each objective can be attained by one of several alternative program actions. Consequently, as the fifth step the decision-maker must choose between the alternatives and implement the one which is preferable.

Once again, there are evident links to an MBO approach if the system manager wishes to choose that process. But, the systems approach as described can be adapted equally well to other management styles.

V. Summary

Systems concepts provide an integrated approach to management. The benefits of this approach include translation of management goals into operational definitions, assurance that all components of the system are incorporated in the management process, provision of a model that facilitates analysis of interactions between goals for various characteristics of individual components and between different components and establishment of a process by which the system can modify its behavior in the light of what it has "learned" about past performance.

The key concepts are often familiar, but they sometimes are obscured by new terminology. Some of the most significant of these concepts are hierarchy of systems, the black box, feedback, policies, criteria, and standards. Each of these has a major role in the structure of the systems approach.

The application of these concepts is an iterative process, but it must be described sequentially for clarity of explanation. The following are the steps in the sequence.

1. Establishing a policy statement which provides the overall system aims in broad terms.

2. Identifying the components of the system through a process of analysis. These components are structured as hierarchy of subsystems.

3. Translating the policy statement into specific criteria and standards which describe each subsystem on several attribute dimensions. An analysis of interaction between various standards for a subsystem and between subsystems is an integral part of this step.

4. Designing a process for collecting, storing, and analyzing data concerning the performance of the system. The analysis is called evaluation.

5. Making adjustments to the system's operation on the basis of information gained from evaluation. These adjustments may be modified if information concerning the system's environment suggests that in the future the circumstances in which the system operates will be different from the conditions that prevailed when evaluation data were collected.

Although the process described represents a fully usable approach to management, there are additional concepts which can be adopted to increase the power of this method. Three were discussed. The first involved expansion of the range of concerns to include all four functions of a system. The second dealt with the use of the systems approach to allocate managerial responsibilities. Particular reference was made to the problem of dealing with differing expectations of professionals and clients.

The final recommendation dealt with the potential of the systems approach for long-range planning as well as for management of current activities.

TRIBUTE TO HONORED GUESTS*

by

Virginia B. Longest

HONORED GUESTS:

Dorothy V. Wheeler, Director, Nursing Service 1946-1954
Ruth Adams Middleton, Deputy Director, Nursing Service 1947-1964
Cecilia H. Hauge, Director, Nursing Service 1954-1966
Mary Jane McCarthy, Director, Nursing Service 1966-1971

Deciding the best way to recognize our distinguished guests was no easy task. In fact, it required a summit meeting of the entire Central Office Nursing Staff. Several suggested the historical approach, while others felt it was more appropriate to focus on accomplishments, honors, or special recognitions previously bestowed upon those being honored this evening.

As we reflected on all of these ideas and reviewed the past, one common thread seemed woven into the career of each. This was the thread of vision, strong leadership, wisdom, and progressive ideas, ideas in advance of their times.

Another idea ahead of the time is the theme used for our conference, "Facing the Future." In reading the last issue of the American Nurse, I note that the theme selected for the American Nurses Association Convention for 1976, is "A Past to Remember, A Future to Shape." The VA Nursing Service is leading the way again with this workshop and our theme.

During this week in which we considered some aspects of designing a futuristic nursing program, we have not looked back. Tonight, however, we have reached an important point, and need to look at the past, a past which was exemplified by the dauntless spirit of these former leaders, our honored and distinguished guests, who have given us a proud and stately heritage.

Each of our distinguished guests is a role model within the framework of her time. It is fitting we honor these outstanding leaders of the Veterans Administration Nursing Service during International Women's Year. The triple goals of IWY are compatible with the goals and accomplishments of the VA Nursing Service.

From 1946 to 1954 during Dorothy Wheeler's administration, the tapestry of the VA Nursing Service was designed. The characteristics of the design were to make the VA Nursing Service one that others would look to, emulate, and view as an example of excellence. A philosophy was clearly enunciated which emphasized the need for education in order to achieve quality nursing practice. Standards and policies were established to foster the concept of quality, and today quality care has become our professional commitment. The grade requirements for nurses were based on professional nursing education, experience, and demonstrated accomplishments rather than on positions. The use of professional standards has been the hallmark of VA Nursing Service. Although these ideas were new thirty years ago, the fabric has stood the test of time.

In 1946, Dorothy Wheeler stated, "I believe that nursing, as a profession, has much to offer the people of the world, in assisting them to develop an awareness of public health, and the degree to which each individual in a community contributes to that health." The challenge to implement this concept was given to Ruth Adams Middleton in 1947.

She brought to the VA Nursing Service her rich, professional experience in public health nursing. Ruth Middleton's contribution to programs in Outpatient Clinics, Regional Offices, hospital referrals and community

Talk given at the Veterans Administration Banquet, Workshop for Chiefs, Nursing Service, November 13, 1975, Bethesda, Maryland.

health were the threads that she wove into a tapestry of alternatives to institutional care, a forerunner of the ambulatory care program as we know it today. During Ruth Middleton's tenure as Deputy Director, Nursing Service she wove the threads of community health and helped integrate public health nursing into the total health care delivery system.

In 1954, Cecilia Hauge with her military, academic, and prior VA experience brought another dimension of leadership. This was the belief, that, education, research, and practice were the integral components of a Nursing Service. Affiliations were begun with schools of nursing and the first research program in Nursing Service was initiated. Nurses prepared at the Doctoral level were recruited for nursing research positions. The first joint appointments of VA nurses were established between university schools of nursing and VA Nursing Service. Programs for Nurse Resident and Nurse Intern were approved. During her three term tenure, Cecilia Hauge directed a Nursing Service with wisdom and vision that kept alive the heart of nursing through the art of caring for patients, despite major organizational, social, economic, and technologic changes.

In 1966, when Mary Jane McCarthy began her tenure as Director, Nursing Service some of these changes had become pressures. These pressures were beginning to have major impact on nursing personnel. Shortages of health manpower led to intensive involvement to establish new training programs for all health personnel. Nursing Service was bombarded by changes occurring from legislation. Various health workers were trained by nurses, and career mobility came into being. Labor relations became a part of the day to day operation, and gave the tapestry a new dimension. Shortage of nurses characterized this era, and nurses began to voice dissatisfaction with staffing that was affecting the quality of patient/client care.

Mary Jane McCarthy had the stamina and fortitude to implement a system-wide staffing study. The study established and conducted during her tenure was used as a model by other health systems. The MEDICUS program came into being as a spin-off of this staffing study.

Undoubtedly, you recognize that due to our time limitations, I am identifying only a few highlights in the professional careers of each of these VA nursing leaders, whom we honor here tonight. It is evident that our past is rich. Each individual in the VA Nursing Service in a leadership role is responsible for continuing to improve the present fabric, and to add new, visionary, and courageous designs to the tapestry so future generations will inherit a Nursing Service of excellence.

BANQUET NIGHT

Pre-Banquet gathering

Receiption line prior to the Banquet

Left to right: Former Director, Nursing Service, Miss Cecelia Hauge; former Assistant Director, Mrs. Ruth Addams Middleton; former Director, Miss Dorothy Wheeler; former Director, Miss Mary Jane McCarthy; present Director, Miss Virginia B. Longest; Depurty Director, Mrs. Gloria S. Hope

AGENDA
Monday, November 10, 1975
Versailles Room

Presiding:	Virginia B. Longest Director, Nursing Service
7:30 a.m.	REGISTRATION
8:30 a.m.	INVOCATION Chaplain James E. Rogers Director, Chaplain Service
	INTRODUCTION–OVERVIEW OF WORKSHOP Virginia B. Longest
9:15 a.m.	REMARKS BY THE CHIEF MEDICAL DIRECTOR John D. Chase, M.D. Chief Medical Director
	RECOGNITION CEREMONY
10:15 a.m.	BREAK
10:45 a.m.	MISSION AND PROGRAM DEVELOPMENT OF PROFESSIONAL SERVICES Lyndon E. Lee, Jr., M.D. Assistant Chief, Medical Director of Professional Services
11:30 a.m.	LUNCH
1:00 p.m.	CHANGING DIMENSION OF THE VA EDUCATION PROGRAM Bill Domm, M.D. Assistant Chief, Medical Director of Academic Affairs
1:45 p.m.	NURSING RELATIONSHIPS: POLICY AND PLANNING Herbert Baganz, M.D. Assistant Chief, Medical Director for Policy and Planning
2:30 p.m.	BREAK
3:00 p.m.	AMBULATORY CARE PROGRAM Edgar A. Reed, M.D. Deputy, ACMD for Ambulatory Care
3:45 p.m.	NURSING SERVICE IN THE VA ORGANIZATION Eugene M. Caffey, Jr. Deputy for Clinical Support Services
	Virginia B. Longest

Tuesday, November 11, 1975

Presiding: Virginia B. Longest

Program Coordinator: Gloria S. Hope
Deputy Director Nursing Service

8:15 a.m. SYSTEMS APPROACH
Phillip Reeves, PhD
Associate Professor
Health Care Administration
George Washington University

9:15 a.m. SUBSYSTEMS IN NURSING
Gloria S. Hope

10:00 a.m. GROUP DISCUSSION OF PROPOSED SUBSYSTEMS

11:00 a.m. GROUP REPORTS

11:45 a.m. BREAK

1:00 p.m. GOAL SETTING AND EVALUATION
Phillip Reeves, PhD

2:00 p.m. GROUP DISCUSSION OF ATTRIBUTES

3:15 p.m. GROUP REPORTS

4:00 p.m. SUMMARY AND EVALUATION
Phillip Reeves, PhD

Wednesday, November 12, 1975

Presiding: Virginia B. Longest

Program Coordinator: Gertrude Keough
Chief, Nursing Career Development
Systems

8:15 a.m. PROFESSIONAL ACCOUNTABILITY
Scott Simonds, PhD
Professor of Health Education
School of Public Health
University of Michigan

9:30 a.m. GROUP WORK

10:45 a.m. IMPACT OF NEW ROLES IN NURSING
Faye Abdellah, EdD
Assistant Surgeon General
U.S. Public Health Service

11:45 a.m. LUNCH

1:00 p.m. DISCUSSION WITH FAYE ABDELLAH, ED.D.

1:30 p.m. THE PRIVACY ACT: PANEL DISCUSSION
Dale Tresidder
Director, Evaluations and Systems Service
A/A for Personnel

Mr. John Campbell
Medical Administration Specialist
Medical Administration Service

Kenneth M. Meyer
Assistant General Counsel

2:30 p.m. BREAK

3:00 p.m. NURSING SERVICE FACES THE FUTURE
Virginia B. Longest

4:00 p.m. THE ROLE OF RESEARCH IN NURSING
Marguerite T. Hays, M.D.
Director, Medical Research Services
and
Deana Cross, Ph.D.
Chief, Nursing Research and Development Programs

Thursday, November 13, 1975

Presiding: Virginia B. Longest

Program Coordinator: Sydney A. Gosman
Director, Executive Training Center

8:30 a.m. TRENDS IN VA LABOR RELATIONS
Leon M. Cornfeld
Assoc. Asst. Administrator for Personnel

9:15 a.m. LABOR RELATIONS CASE STUDIES AND CONCURRENT GROUP WORK
Michael Rudd
Director, Labor-Management and Employee
Relations Service

10:15 a.m.	LABOR RELATIONS CASE STUDY REPORTS Concurrent Group Leader Panels
11:45 a.m.	LUNCH
1:00 p.m.	OPEN FORUM ON NEGOTIATED AGREEMENTS Resource Panel: Central Office Personnel
2:00 p.m.	GRIEVANCE ADMINISTRATION AND ARBITRATION IN VA Howard E. Steinwandel Chief, Labor Relations Division Robert C. MacDonald Labor Relations Specialist Beatrice E. James Chief, Nursing Service Programs
3:30 p.m.	UNFAIR LABOR PRACTICE COMPLAINTS: THE VA'S EXPERIENCE Robert V. H. Dwinelle Chief, Labor Relations Policy Division Norman E. Jacobs Senior Labor Relations Specialist
6:30-7:30 p.m.	NO-HOST COCKTAIL HOUR
7:30 p.m.	*BANQUET*

Friday, November 14, 1975

Presiding:	Virginia B. Longest
8:00 a.m.	MEDICAL DISTRICT GROUP CONFERENCES Central Office Nursing Staff
9:45 a.m.	BREAK
10:15 a.m.	DISCIPLINARY ACTIONS AND GRIEVANCES Carl E. Sickles Chief, Employee Relations Division Office of Personnel
11:15 a.m.	FUTURE OF THE VETERANS ADMINISTRATION Odell W. Vaughn Deputy Administrator
11:45 a.m.	LUNCH

1:00 p.m. CLASSIFICATION AND PAY ADMINISTRATION ASPECTS FOR NURSING SERVICE
Albert W. Brand, Jr.
Director, Classification and Pay Service

Donald K. Schimmel
Chief of Pay Administration Division

1:45 p.m. EVALUATION
CLOSING REMARKS
Virginia B. Longest

3:00 p.m. ADJOURNMENT

LISTING: Central Office Nursing Staff and Ad Hoc Committee, Chiefs, Nursing Service

CENTRAL OFFICE NURSING SERVICE

Miss Virginia B. Longest	Director, Nursing Service
Mrs. Gloria S. Hope	Deputy Director, Nursing Service
Mrs. Mildred L. Eichinger	Administrative Officer
Dr. E. Deana Cross	Chief, Nursing Research & Development Programs
Miss Ruth H. Bryce	Chief, Long-Term & Ambulatory Care Programs
Miss Alice A. Soehl	Chief, Mental Health Nursing Programs
Miss Gertrude Keough	Chief, Nursing Career Development Programs
Miss Kathleen E. McNamara	Chief, Nsg Service Programs, Dist. 1,2,3
Miss L. Arlene Bence	Chief, Nsg Service Programs, Dist. 4,5,6,7
Mrs. Beatrice E. James	Chief, Nsg Service Programs, Dist. 8, 9,10,11,12
Miss Hazel C. Murray	Chief, Nsg Service Programs, Dist. 13,14,15,16,17,18
Miss Joan Padberg	Chief, Nsg Service Programs, Dist. 19,20,21
Mrs. Donna S. Humes	Chief, Nsg Service Programs, Dist, 22,23,24
Miss Margaret I. Williams	Chief, Nsg Service Programs, Dist. 25,26,27,28

AD HOC COMMITTEE OF CHIEFS, NURSING SERVICE

Miss Helen L. Galena	VAH, Tucson, Arizona
Mrs. Carol J. Gates	VAH, Hampton, Virginia
Mr. Jack Jacob	VAH, Murfreesboro, Tenessee
Miss Yvonne K. Moody	VAH, Allen Park, Michigan
Mrs. Alicebelle Rubotzky	VAH, Providence, Rhode Island
Miss Orena M. Shaw	VAH, St. Louis, Missouri
Miss Corinne D. Tanner	VAH, Temple, Texas

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